Cyngor Gofal Cymru
Care Council for Wales

CARE AT HOME

CHALLENGES, POSSIBILITIES AND IMPLICATIONS FOR THE WORKFORCE IN WALES

FINAL REPORT

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Welsh Institute for Health and Social Care
Sefydliad Iechyd a Gofal Cymdeithasol Cymru

Insight Social Research Ltd

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TABLE OF CONTENTS

Care at Home: challenges, possibilities and implications for the workforce in Wales

APPENDICES

LIST OF BOXES

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Thanks are due to the Care Council for Wales for commissioning this study and providing direction at the outset. We would like to recognise the role of Toni Leggett at the beginning of the process, and Gerry Evans, Sioned Williams and Sheila Lyons – all of the Care Council for Wales – in managing the project and assisting the study throughout. In addition the role of the Project Steering Group has been crucial in ensuring the research has remained grounded in the realities of care at home, and for providing rigourous and appropriate challenge where required.

As with any such research, this project was only possible thanks to the contributions of the participants – their willing engagement with the study, openness and honesty is gratefully acknowledged. The number of participants stretches into the hundreds – whether service users, carers, front line care workers, direct service managers, other managers, commissioners or other stakeholders – and we wish to acknowledge their role. We hope that the engagement of these individuals throughout the process has given it a rigour and reality check that is welcomed by all.

The report provides the Care Council for Wales, Welsh Assembly Government, local authorities, care at home providers and other key stakeholders a series of recommendations about the future of care at home and its workforce. These are based on our interpretation of the evidence presented to us by participants and the extant data. The analysis offered here is entirely our own and any errors of interpretation are solely due to the authors.

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INTRODUCTION

The Welsh Institute for Health and Social Care, University of Glamorgan with Insight Social Research and The Management Standards Consultancy were commissioned by the Care Council for Wales (Care Council) to undertake a study on the professional care at home workforce and the implications for the workforce of moving towards new ways of working.[1] In short, the project was commissioned to answer three key questions:

1. **What does the care at home workforce currently look like?**
2. **What is the future vision for care at home and its workforce?**
3. **What do we need to do to move the current workforce towards the vision?**

The study began in Autumn 2008 and this document is the culmination of much information gathering over 18 months. The methodological approach[2] taken by the research team[3] to answer these questions was a broad and inclusive one:

- **including working across different client groups:** acute and chronic illness, frailty, learning disabilities, mental health and physical disabilities and sensory impairment;
- **fully exploring the realities of care at home:** research with service users, carers and care workers, as well as all of those that manage, assess and commission them;
- **understanding the reasons for variation in challenge:** age, gender, complexity of need, ethnicity, rurality, language of choice etc;
- **responding issues raised by Steering Group:** procurement and commissioning, recruitment and retention, training, qualifications, resources, data, policy.

By way of introduction and before engaging with any of the detail of the issues and possible solutions below, it might be useful to reflect on what the current challenges and pressures in providing care at home in Wales. These are represented in Figure 1. The diagram provides an illustration of the strategic challenges and operational pressures facing care at home services across Wales currently. What it emphasises is the complex nature of interactions needed to ensure that the 11.7 million hours of care at home – 44% of which is provided by 6,857 local authority staff and 56% of which is delivered by an estimated 8,727 independent sector workers – to the 25,000+ service users in Wales in addition to the nearly 300 million hours of unpaid care provided by carers is sustainable and of high quality (Statistics for Wales, 2009).[4]

In responding to the three key questions above, this document is presented in three sections. Section 1 provides the Context for the study both in terms of the policy and legislative backdrop to care at home, and the data that is currently held on the workforce. It tries to answer the first question: what does the care at home workforce currently look like? Section 2 captures all of the Research Findings that were gathered during the course of the project and is presented according to the key themes that emerged. In addition it provides evidence for the second question about the future vision for care at home and its workforce. Section 3 contains Conclusions and Recommendations for consideration by the Care Council and other stakeholders. Its primary purpose is in providing an answer to the third key question: what do we need to do to move the current workforce towards the vision?

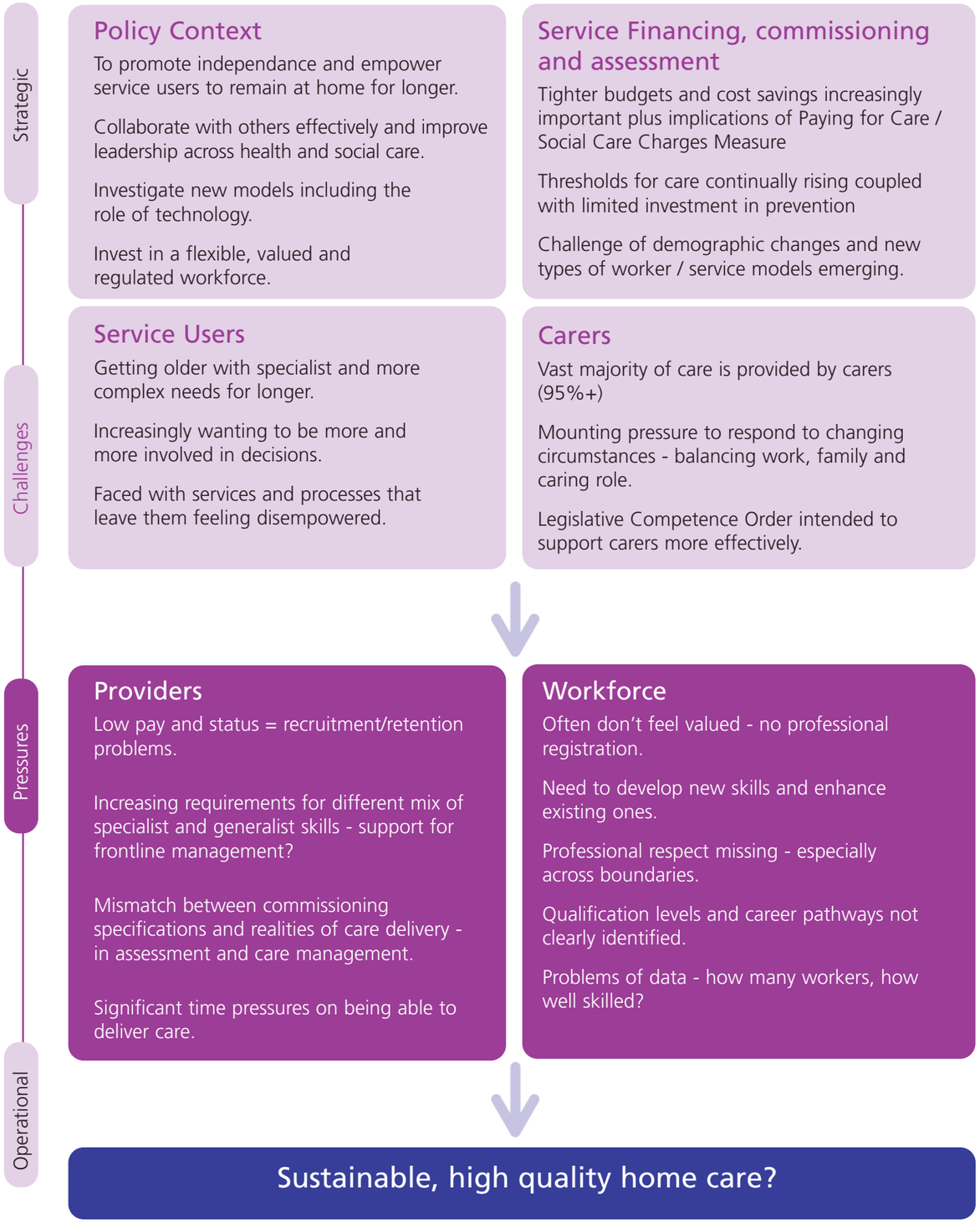
[1] The original Terms of Reference are reproduced at Appendix 1. A number of these have evolved as would be expected during the course of a study as this. All of these evolutions have been discussed and agreed with both Care Council and the project Steering Group.

[2] An outline methodology is provided in Appendix 2.

[3] The research team consists of Dr Mark Llewellyn, Professor Marcus Longley, Marina Roberts (all of Welsh Institute for Health and Social Care, University of Glamorgan), Dr Carolyn Wallace (Faculty of Health, Sport and Science, University of Glamorgan), Dr Malcolm Fisk (Insight Social Research) and Trevor Boutall (The Management Standards Consultancy).

[4] See Section 1.2 for the detail behind these figures.

Figure 1 | Current challenges and pressures facing care at home services in Wales



Care at Home: challenges, possibilities and implications for the workforce in Wales

SECTION 1 | Context

1.1 | POLICY BACKDROP AND SCENE SETTING

This study and report are deliberately entitled to incorporate the workforce implications of '*care at home*'. What this signifies is a concerted effort to engage a range of issues at the boundaries of where current home (or domiciliary) care begins and ends, even though this boundary is a dynamic and fluid one. Everything that follows should therefore be read in the light of this, and at times the report will move well beyond the current remit of the Care Council for Wales – in thinking through the implications for carers and personal assistants (PA's), for example. That said a natural starting point when considering some of these issues relates, of course, to the statutory definition of domiciliary care.[5]

1.1.1 DEFINITION, REGULATION AND BOUNDARIES

In February 2010 the Law Commission published a consultation paper on adult social care law in England and Wales and it is useful to see everything that follows within the legal framework specified in their paper in which care at home operates.[6]

The agencies that provide care at home in Wales are substantively regulated, and consequently registered with the Care and Social Services Inspectorate Wales (CSSIW). In terms of regulations the key reference points are the Care Services Act 2000 (and its various versions)[7], the Registration of Social Care and Independent Health Care (Wales) Regulations 2002, and the Domiciliary Care Agencies (Wales) Regulations 2004 (National Assembly for Wales, 2004). These set out what is included and what is excluded and, by so doing, determine the current boundaries for domiciliary care in Wales. Included in the definition is '*personal care*' which involves:

> *'assistance with bodily functions such as feeding, bathing, walking and toileting; and care which falls just short of assistance with bodily functions, but still involving physical and intimate touching.'*

In addition the Welsh National Minimum Standards (Welsh Assembly Government, 2004) clearly seek to underpin domiciliary services that *'work with'* rather than '*do for*' service users. They note that '*care workers will be providing support and assistance to people with a range of disabilities, helping them to maximise their own potential and independence.*' In addition to providing physical help the standards recognise a primary responsibility for those involved in the provision of domiciliary care to '*improve the protection afforded to vulnerable people receiving care in their own homes*'. This might include '*checking, prompting and/or ongoing supervision*' for people with dementia or learning disabilities, as well as

[5] The definitional difference between domiciliary care as defined in law and statute and the practice of care at home is one to which the report will return.

[6] A summary of the main community care statutes is provided in Appendix 3. Incidentally the Law Commission consultation may have far-reaching consequences for the conclusions and recommendations listed here.

[7] The Care Standards Act 2000 and the Children Act 1989 (Regulatory Reform and Complaints) (Wales) Regulations 2006; The Care Standards Act 2000 and Children Act 1989 (Amendment) (Wales) Regulations 2004; and The Children Act 1989 and the Care Standards Act 2000 (Miscellaneous Regulations) (Amendment) (Wales) Regulations 2002

assistance with '*medication requirements and other health related activities*'. More clearly defined in the standards are the tasks deemed as '*general counselling and support*'. These fall outside the definition of personal care – and essentially relate to landlord functions and '*good neighbour*' tasks of the kind associated with the traditional sheltered housing warden role. The Welsh standards, while offering a good basis by which domiciliary care tasks are delimited, point to areas at the boundaries that can be, and are, contested. In addition to this, the Domiciliary Care Agencies Regulations provide an insight into the boundaries of formal regulation. As noteworthy in this context are those agencies that fall under the auspices of the Regulations as those that do not. An undertaking is excepted from the definition of '*domiciliary care agency*' in section 4(3) of the Act if it is carried on by an individual who:

- **(i)** carries it on otherwise than in partnership with others;
- **(ii)** is not employed by an organisation or unincorporated association to carry it on;
- **(iii)** does not employ any other person for the purposes of the undertaking; and
- **(iv)** provides or arranges the provision of personal care services to fewer than four service users

This would include many people employed as Personal Assistants (PAs) the number of which is likely to increase as moves to personalise services gather momentum.

Care and support – what do we mean?

Whilst providing definitions it is worth clarifying at this point the terms care and support. They are frequently used interchangeably when discussing the role that workers undertake within the home. However, previous studies have indicated that service users such as older people want certain values from the services they receive in the community. These include clarity of care, continuity, reliability, consistency, competence, flexibility and person-centredness (Scourfield, 2007; Shield et al, 2006). There is interdependence between concept clarity and operational delivery and so it is important to be clear as to what we mean by the act that workers undertake at home.

Care has been defined in a number of ways. The Oxford Dictionary of English states that it is the '*provision of what is necessary for the health, welfare and maintenance and protection of someone or something*'. Alternatively Leininger (1981) defines care as '*those assistive, supportive or facilitative acts toward or for another individual or group*'. Consequently the care worker is defined as '*a person employed to support and supervise vulnerable, infirm, or disadvantaged people, or those under the care of the state*'. Unfortunately, these definitions and the term care itself are often confused with words such as '*concern*' and '*compassion*' which invoke emotive and sometimes negative feelings of worry or sympathy.

Alternatively, the evolving role of the support worker is defined as working '*under the supervision of registered practitioners*', such as the social worker and occupational therapist. Increasingly, the role of the support worker within the home setting is there to support the facilitation of positive outcomes such as independence and autonomy, supporting individuals in their bid '*to act according to their own direction*'. Basically, they support both registered practitioner and service user in '*unlocking*' their potential to live independent and fulfilling lives (Brooker, 2007; Manthorpe and Martineau, 2008). This is achieved through complementing and supporting the plan of care developed with registered practitioners and service users.

In addition, the remit of the supporting role varies between settings and depends upon the nature and services required to meet individual need. Promoting independence and autonomy is reflected through numerous tasks undertaken to meet those diverse needs and includes providing physical and emotional support and maintenance, whilst sharing information appropriately. All of this is achieved through the principles of a person-centred approach – individuality, choice and equity (Wallace and Davies, 2009). Using a person-centred approach enables empowerment so that the individual makes decisions about his or her presenting situation. Central to its practice is respect for the person's values and how the individual understands and perceives what is happening to them, in comparison with their usual or expressed behaviour. Therefore the role of the support worker is included as an integral part of the system of meeting individual needs and reaching the values, planned goals and outcomes which service users desire.

Defining 'Care at Home'

Whilst the report is deliberately wide-ranging, the care at home workforce that we primarily refer to is the social care one. It encompasses what has commonly been known as the domiciliary care, or home care workforce, although there are a range of exceptions to this and the focus is broader than just home care. For example, we do not overlook the relationship between home care and other parts of the social care workforce – especially unpaid carers who provide the vast majority of care in Wales. Included in our analysis have been service users and providers in receipt of different funding monies like Supporting People for example. The research has inevitably focused at times on older people given the preponderance of care at home service users classified as such. However wherever possible those with physical or learning disabilities, mental health problems, acute care needs and frail older people were consulted. All of this means that when '*care at home*' is referred to there is no direct read across to what most people would know as domiciliary or home care – the terms of reference here are much broader than that.

1.1.2 STRATEGIC AGENDAS

The documents cited above do not debate the considerable range of issues that might, in due course, lead to changes in the range of tasks undertaken in the homes of people for which there are workforce implications that might need to be regulated. These tasks are of course influenced by people's aspirations, the extent of their needs and the service delivery options available.

These are matters for the strategies of the governments of the UK in relation to the models of care and support adopted. They are impacted upon by a range of demographic, social, economic and political changes such that past, and to an extent current, definitions of care at home are increasingly open to debate. The strategies of the Welsh Assembly Government (Assembly Government) are clearly central here but key Department of Health and European Commission publications are also referenced because of their importance in signalling the broader context for social services.

European Perspective

Specific attention to social services, including those provided in the home, is given in an overview that references the key demographic trends across Europe (European Commission, 2008b). The document refers to the growing significance of '*social services of general interest (SSGIs)*' in '*promoting an inclusive society and in enhancing the capacity of individuals to participate fully in society*'. Noted is the trend towards states becoming less involved in direct service provision but having an increasing role as regulator or guarantor. It is significant that the European Commission intends to promote an EU quality framework for SSGIs, focused on person-centred services, prevention, and quality of life issues. While there is only limited specific attention to domiciliary care, the need for more pro-active ('*anticipatory*') and rehabilitative services in the community is strongly affirmed. There is also significant focus on issues at the health and social care interface – the integration of such services being a theme in many European countries.

Alongside the foregoing appraisal is an upbeat factual summary of home care in twelve different European countries provided by the World Health Organisation (Tarricone and Tsouros, 2008). It refers to '*home (domiciliary) care*' as an '*increasingly promising option*' that has the '*potential to explore, exploit and implement an old idea with today's knowledge and new means.*' The role of home care is seen as one that '*keeps families together*', '*promotes healing*', allows '*maximum freedom for the individual*' and is '*personalised, tailored to the specific needs of each individual.*' Of particular note in the report is an analysis of changing needs of the potential role of technologies and devices (both low and high-tech) in supporting a wider range of people at home.

Department of Health Perspective

The UK Government, or perhaps more accurately English, perspective is best summarised by reference to two documents, both emanating from the Department of Health. The first, the White Paper, '*Our Health, Our Care, Our Say: a new direction for community services*' (Department of Health, 2006) outlined a '*radical*' reform programme for England that was concerned to secure a breaking out from traditional health and social care service frameworks and, importantly, facilitate closer working between the sectors. In its words, it '*sets a new direction for the whole health and social care system*' in which there are more personalised services. The second document – the '*Putting People First*' concordat[8] – (Department of Health, 2007a, and the accompanying workforce strategy, Department of Health 2009c) aimed, with the support of a range of agencies, to increase the speed by which health and social care agencies move towards '*transformation of adult social care*' a key element of which is personalisation.

The proposals set out in '*Our Health, Our Care, Our Say*' amongst other things aimed at '*putting people more in control and shifting to a greater emphasis on prevention*' (Department of Health, 2006). It resonates, therefore, with key points made by the European Commission in its overview of social services within member countries. '*Putting People First*' attempted to give impetus to the required changes. Importantly, however, it placed such reforms in a context that recognised broader agendas including that relating to social isolation. Underpinning all of this the workforce strategy '*Working to Put People First*' (Department of Health, 2009c) identified a range of actions to '*ensure entry level training, continued professional development and workforce registration to reflect the new skills required in a personalised system.*' The document pointed to six priority areas for the development of the social care workforce:

- Leadership including effective management and commissioning skills which are crucial to the transformation of adult social care;
- Recruitment and retention which particularly in some areas remains a challenge;
- Workforce remodelling and commissioning ensuring the workforce has the right people with the right skills providing services people want;
- Workforce development aiming to create a more confident, empowered and diverse workforce
- Joint and integrated working between social and health care and other services so that service users can be assured that the workforce will operate across organisational boundaries; and
- Regulation, assuring public safety and raising standards of care in the social care workforce, a priority for employers and for the professional regulator (General Social Care Council)[9] and the service regulator (Care Quality Commission).

[8] Partner agencies to the concordat included the Commission for Social Care Inspection; the General Social Care Council; Skills for Care; and the Social Care Institute for Excellence.

[9] The General Social Care Council (GSCC) was expected to open a voluntary register of home care workers from early 2010 but in discussion with the Department of Health, the GSCC has decided to put on hold the planned roll out of registration of other parts of the workforce.

Care at Home: challenges, possibilities and implications for the workforce in Wales

Wales Perspective

The Wales perspective is set out in a number of key documents. Not all are noted at this juncture[10] but the strategic documents referenced here echo those for England in pointing to the need for major reforms in health and social care. Many of the required steps to achieve these reforms are indicated in them, especially the recent review of social services in Wales undertaken by CSSIW and the Welsh Audit Office (CSSIW and WAO, 2009). It is useful to note however that a major stimulus, by which the need for reform was recognised, lay in the '*Wanless Report*' (Welsh Assembly Government, 2003) that reviewed health and social care in Wales which built on the policy direction indicated in '*Improving Health in Wales*' (Welsh Assembly Government, 2001). Amongst other things, the Wanless Project Team called for a '*strategic adjustment of services to focus them on prevention and early intervention (with) adjusted roles for social, primary and secondary care*'. They suggested a '*new integrated framework for service delivery including…social care support which enables people to stay in their own homes and facilitates discharge from hospital*'. Workforce planning required greater attention in relation to '*future models of service provision*'. The Wanless Report was followed by an Audit Commission study that strongly called for partnership working, including for the delivery of health and social care '*across local government and local NHS bodies*' (Audit Commission, 2004).

In 2005 the Assembly Government strategy '*Designed for Life*' called for continuation of the '*wholesale transformation of services and their delivery*' and offered a vision for 2015 (Welsh Assembly Government, 2005). With reference to the Wanless report, it asserted that '*progress will mean change, probably in every hospital, GP practice and every social service department…we have no choice*'. Amongst other things it made clear that services provided to people at home or the local community (including supported housing, primary care resource centres, social care support services, intermediate and continuing care) would be '*greatly strengthened*' with an expansion of: '*prevention, screening, community-based assessment, carer support, rehabilitation and intermediate care, as well as domiciliary and respite care, and supported housing and home-based technology.*'

This list is helpful in pointing to that multiplicity of tasks and roles often undertaken in people's homes, and which relate in one way or another to the care at home workforce.

More recently primary and community services have been at the forefront of discussions in health, and at the interface between health and social care. The Community Resources Teams, as described in '*Setting the Direction*' (Jones et al, 2009a) – the paper of the Primary and Community Services Strategic Delivery Programme – are envisaged to include social workers among others with advanced skills to work collectively to '*create a strong, multi-disciplinary approach, focused on the maintenance of more complex cases in the community*'. Whilst not named there are obvious implications here for care at home workers and the way in which their roles may evolve.

More specific to social care was a series of publications on workforce issues, beginning in 2001 with the report of a Task and Finish Group established by the Minister of Health and Social Services. This established the principle that the social care workforce should be viewed as one workforce operating in one sector. The then Social Services Inspectorate for Wales subsequently published '*Planning for Caring*' (2003) which was guidance for local authorities and partner organisations to draw up effective human resource plans for the social care sector in their area. This was supported by '*Planning for Training and Development Across the Social Care Sector*' which provided similar guidance in respect of effective training and staff development arrangements. The Training Support programme was replaced by the Social Care Workforce Development Programme placed a new emphasis on collaboration and partnership working. The advent of the Care Council for Wales in 2001 gave fresh impetus to meeting the challenge of achieving a sustainable social care workforce and a programme of registration was begun. New Regional Social Care Partnerships were established to provide a strategic approach to employment and skills issues. Later, the Care Council adopted the role of the Sector Skills Council for Wales joining with the other three countries in a UK Alliance.

[10] These include those that relate to the needs of particular groups of people (e.g. older people and people with mental health problems).

The ten-year strategy '*Fulfilled Lives, Supportive Communities*' followed in 2007 (Welsh Assembly Government, 2007a). This document set out how the Assembly Government intends to carry out the reforms to social services that form part of its '*modernisation*' agenda.[11] There is an echo here of the modernisation agenda as set out by the Department of Health (2007b) which saw the need to make sense of a '*confusion of roles.*' Of the service user the strategy affirmed that:

> *'People should be supported to have control over the life they wish to live. People have a right to expect services which help them to make full use of their potential, protect them from harm and offer a choice about how they are supported.'*

Accompanying this was the commitment to '*drive up*' standards in relation to which the important contributions to date of the Care Council and CSSIW were acknowledged. Opportunities identified included those arising from partnership working; through the benefits of having '*better informed and empowered service users*'; and the adoption of '*new models of care*'. Specific responsibility was given to the Care Council with regard to issues around planning the future social care workforce – as a prelude to the Assembly Government consulting on '*extending registration across all groups of social care workers incrementally*'. In this regard the priorities for the workforces as identified in the Care Council's '*Fulfilled Lives, Supportive Communities: Workforce Action Plan*' (Care Council for Wales, 2007) are important to consider. The Workforce Action Plan Stakeholder Group identified five key areas for development in the first three years of implementing '*Fulfilled Lives, Supportive Communities*' (i.e. 2007-2010).

These were focused on:

- The workforce for services to children and families;
- The workforce to support people living at home;
- Development of workforce information and planning;
- Improved communication with the social care workforce; and
- Supporting recruitment and retention to the sector.

It is also worth noting that the '*One Wales*' document set out a series of commitments agreed between the Labour and Plaid Cymru groups in the National Assembly (Welsh Assembly Government, 2007b).
A number of these workstreams are underway, but the following will have an impact on services provided in people's homes:

- improving quality provided to vulnerable people and creating '*seamless care pathways*';
- promoting people's independence and the potential to achieve their '*full potential*';
- reviewing the Carers Strategy and legislating on their rights; and
- giving a strong emphasis to work-based training for care staff; and
- piloting multi-purpose well-being centres.

[11] There are now a number of supporting documents which are aimed at helping to achieve the broad vision set out in '*Fulfilled Lives, Supportive Communities'*. See, amongst others, the recent consultation on the '*Fulfilled Lives Supportive Communities Commissioning Framework and Guidance*' (Welsh Assembly Government, 2009a), the '*Statutory Guidance on the Role and Accountabilities of the Director of Social Services*' (Welsh Assembly Government, 2009b), and '*Securing Strong Partnerships in Care*' (Welsh Local Government Association, Association of Directors of Social Services Cymru, Care Forum Wales, the Registered Nursing Home Association and the UK Home Care Association, 2009) – the memorandum of understanding between a range of key stakeholders as relevant examples.

Care at Home: challenges, possibilities and implications for the workforce in Wales

The recently announced Independent Commission on Social Services has given added zeal to discussions about the future provision of social services and social care over the next decade in Wales. The Deputy Minister for Health and Social Services has asked the Commission to consider how the Assembly Government can: support the further development of professional practice; build inclusive social services based on the contribution of all partners who work in social care; effect a step change in collaboration between social services and with other key services; and ensure integrated social services are capable of meeting needs in the most effective way. In considering these issues the Commission will be asked to have regard to the impact of changing public expectations, demographic changes and a range of resource scenarios that ensure a sustainable service. The Commission will also be asked to have regard to the wider policy context including:

- The principles set out in '*Fulfilled Lives Supportive Communities'*;
- The Assembly Government Green Paper on '*Paying for Care*' and the outcome of the consultation on the Green Paper;
- Ministerial commitments to review the future funding of social care and social services;
- The Task Group on the future of the social work and social care workforce;
- The Assembly Government led public service reform programme, including the evolving arrangements for local government and health services; and
- The community and primary care framework.

The Commission's work is currently underway and will report in November 2010.

1.1.3 FUNDING SOCIAL CARE – GREEN PAPERS IN ENGLAND AND WALES

One of the most significant issues on which the Commission has been asked to comment is on the future payment for social care. This is of huge significance and one which reaches far beyond the bounds and remit of this project, but given that it does bear so closely upon the long-term sustainability of care at home it merits serious consideration.

There have now been green paper consultations in both England and Wales on paying for social care in the future. In England '*Shaping the Future of Care Together*' (Department of Health, 2009d) and in Wales '*Paying for Care*' (Welsh Assembly Government, 2009c) both set out the case for change. They described the rather complex and cumbersome current system of multiple funding streams (UK, Local Authority, individual, insurance, voluntary) and pointed out that it offers an unsustainable match for the four key principles on which such a system should be based:

- universal (i.e. it covers everyone);
- affordable, sustainable and fair (balancing the priorities of people of different levels of wealth, different ages and different levels of need);
- clear, so that people understand what they must do to be part of the system, what help they will get if they need care, and how to access that help; and
- helps people to live independently, in control of their own lives and making their own choices (in accordance with their capacity), so that they receive high quality care when they need it.

Both papers then offered specific proposals for how social care might be afforded into the future. Whilst they did not specify the particular impact on care at home, they shared a common basis in recognising five possible models for future funding:

1. Pay for yourself – everybody responsible for paying for their own basic care and support, when they needed it;
2. Partnership – the state will pay a quarter to a third basic care and support to those who qualify with additional help for the less well off;
3. Insurance – everyone would be entitled to have a share of their care and support costs met, with private or state insurance schemes to cover the cost of additional care and support;
4. Comprehensive – everyone over retirement age who can afford to pay would be required to pay into a state insurance scheme;
5. Tax-funded – people would pay tax throughout their lives, which would be used to pay for all the people who currently need care.

Both consultations also shared the basic premise that they ruled out the '*pay for yourself*' option, and although the language in Wales was not specific they both effectively ruled out the '*tax-funded*' option. What is made clear in '*Paying for Care*' is that the '*Comprehensive*' option comes closest to the preference expressed by the Wales Advisory Group. The consultation closed in England on 13th November 2009, and in Wales on 28th February 2010. White Papers are expected in both countries during 2010.

The key question for this study to consider is what are the implications for care at home of these discussions about funding? This is almost impossible to determine at this juncture given that the consultation has only just closed, but there are indications of the direction of travel in Wales from other sources.

One aspect of this is a new regime for charging which will ensure that local authorities across Wales adopt a more consistent approach to charging service users for non-residential social care services. The '*Social Care Charges (Wales) Measure*' will limit charges for social care in Wales to £50 per week (current charges range from £16.20 to £200 with some Local Authorities having no upper limit), with no charge for transport to day centres and for severe disablement and attendance allowance to be disregarded when assessing ability to pay from 2011. It is anticipated that those with most complex needs and the most vulnerable will benefit from proposed changes. The Measure has received Royal Assent and work will now commence in consultation with stakeholders to draw up the regulations and guidance required to introduce the First Steps Package from April 2011. This new charging regime will clearly have significant and far reaching consequences for the commissioning and delivery of care at home services.

1.2 | KEY PARAMETERS AND KEY FACTS

1.2.1 FOUR CENTRAL CONCEPTS

Further context is provided by moving the discussion towards the care that is actually provided in people's homes. Four key and interrelated parameters underpin most care at home services: the support given by services for a person's functional ability; for their safety; the sensitivity of services to personal needs (person-focused services); and the potential of services to support ablement.[12] These key parameters chart the way in which different service elements have evolved over the last half century, and how care at home services must continue to evolve:[13]

- Functional ability – the ability of a person to function in their home in accomplishing routine tasks;
- Safety – the primacy of ensuring that services provided protect vulnerable people in terms of safeguarding them against harm;
- Person-focused services – ensuring that services must be centred on the person, and that the person must have real choices about the services they access; and
- Ablement – affirming the need for services to help people maintain (or build on) the levels of independence that they have. Whilst re-ablement implies recovering from the effects of adverse personal circumstances, the broader notion of ablement reflects a broader consideration of increasing quality of life.

Figure 2 | Key parameters underpinning domiciliary care

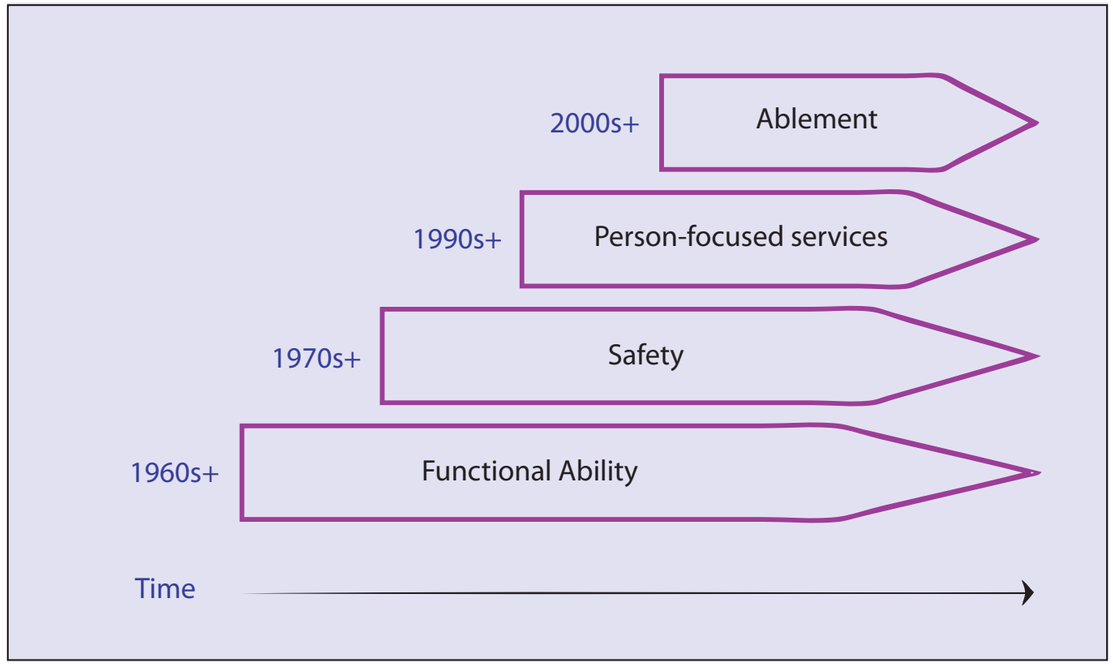


Figure 2 illustrates the chronology of these changes, which bears some resemblance to Maslow's 'Hierarchy of Need' (1970). Maslow considered a need as something you lack which is necessary to sustain life, health and wellbeing. The original hierarchy commenced with 'biological and physical needs' at the lower level (e.g. eat, drink and physical cleanliness); to 'safety needs' (e.g. medication, paying household bills); then to 'belongingness and love needs' (e.g. family and social relationships); 'esteem needs' (e.g. personal and social achievements); and finally 'self-actualisation' (e.g. achieving potential, including independent living) at the highest level. Each of the lower needs have to be met in order for an individual to be able to achieve 'self actualisation'.[14]

[12] We acknowledge that there are a range of needs that do not fit neatly within this typology – those with mental health problems (especially dementia), those with progressive, degenerative disorders and those needing end of life care. Despite this the aim remains to maximise people's independence as far as possible.

[13] Considerable detail on each of these four key parameters can be found by consulting Appendix 4, and the Scoping Report which was published as part of this study – see Llewellyn et al (2009) which can be accessed from http://www.ccwales.org.uk/development-and-innovation/adult-workforce,2

[14] Adams (2007) developed this concept by requiring that 'cognitive need' (e.g. understanding the issues which threaten independence) and 'aesthetic need' (e.g. daily routine) needed to be met prior to self actualisation.

1.2.2 SCOPING THE WORKFORCE – FUNCTIONAL MAP

In order to provide further information about the scope of the functions of the care at home workforce, the research team produced a Functional Map. The Map identifies all the functions which must be carried out to achieve the mission or key purpose of the domain being studied, in this case care at home in Wales. The key purpose was been defined as: to provide non-medical care and support to enable people to live in their own homes. The analysis provided 12 '*key areas*' of activity. The activities can, depending on context, relate to commissioners, regulators and inspectors or the providers of domiciliary care services:

A. Develop understanding and insight about access to and provision of domiciliary care and support;

B. Develop, implement and evaluate policies and strategies for the provision of domiciliary care and support;

C. Commission the provision of domiciliary care and support;

D. Manage services to provide domiciliary care and support;

E. Enable individuals to access domiciliary care and support;

F. Assess individuals' needs for, and rights to, domiciliary care and support;

G. Assess and manage risks involved in providing domiciliary care and support;

H. Specify, plan and review the provision of domiciliary care and support to individuals;.

I. Provide specific planned domiciliary care and support to individuals;

J. Provide support to carers and family members;

K. Independently inspect domiciliary care and support services;

L. Resolve problems regarding the provision of domiciliary care and support.

Having identified all the functions required, underneath each of these key areas databases of National Occupational Standards (NOS) were consulted to find accredited units which accurately describe the standards of performance, knowledge and skills required to carry out the function safely and effectively. The Functional Map for Care at Home in Wales is detailed in Appendix 8.

1.2.3 CURRENT WORKFORCE DATA AND INFORMATION

It is important to recognise that the Care at Home workforce referred to throughout the document is not homogeneous, in the way it is in the NHS with one employer a clear structure and control system. It is a workforce employed across the 354 separate agencies registered with CSSIW across the public, independent and third sector. Each agency is unique and trains and manages its own workforce to meet the specific terms of contract commitments they have at any one time. The size of agencies varies from typically 20-50 workers in small private agencies through to over 200 workers in public sector services. The workforce is therefore highly fragmented.

As such there are huge challenges in being able to research and present data on the reality of the care at home workforce in Wales. Table 1 provides an indication of the variation in quality of data available and demonstrates that this is considerable. The biggest gap in current knowledge pertains to the private and third sector, and for care provided by PAs. In trying to determine basic information about the number, type and quality of care workers operating in Wales two significant issues were faced by the research team:

1. Potential duplication of unidentifiable data - This refers to where it might be possible to collect, for example, the number of agencies accessing training from the Social Care Workforce Development Programme funds but it proves not possible to find out exactly which these agencies are (which is often the case because names of agencies can't be released). In such circumstances it is impossible to guard against the potential for double counting against those agencies registered with CSSIW, for example, and data on agencies is rendered useless.
2. Confusion over the meaning of data labels - Consistently applied definitions of key terms are not in place. So, for example, what does the label 'personal assistant' mean, and is there a universally accepted definition of what a 'personal assistant' does in use? Does it mean the same thing in different places? Without such clarity over data categories, comparison and generalisation about workforce functions, numbers and tasks is meaningless – both between organisations and across the spectrum of care.

The study attempted as far as possible to overcome these shortcomings. There were a number of sources of data which proved to be useful in providing some context, even though each of these sources provides much better information on the statutory than private or third sectors.

Care Council for Wales

Ahead of the commission for this study, the Care Council undertook a survey of the 341 providers of domiciliary care in Wales registered with CSSIW in May 2008 (Care Council for Wales, 2008).[15] The results of the survey pointed to the range of support needs being met – over two thirds at least delivering services to older or disabled people, and to people with learning disabilities or mental health problems. Lower proportions met the needs of people with '*sensory needs*' or with drug/alcohol dependency.

Only one service (of those who responded) was aimed at supporting children. The report noted that of the managers who responded to the survey, three quarters had NVQ Level 4 qualifications and that close to a quarter (27%) were registered with the Care Council. There was an '*encouraging*' level of awareness of the emerging Credit and Qualification Framework for Wales (CQFW); and nearly a quarter (22%) of organisations had 30% or more of staff with NVQ Level 3 qualifications. Broader consultation as part of this report noted the '*diversity of the sector and the provision of services beyond those registered with CSSIW*'; the latter including home helps, befriending and supported housing. The last of these was indicated as a cause for concern with regard to the quality of service provision. Whilst the survey noted the levels of NVQs attained by growing numbers of staff there were concerns about their appropriateness for domiciliary care workers.

Table 1 | Typology of care at home and requisite data quality

Types of care at home	Examples	Possible sources	Quality of workforce data
Statutory sector direct provision	Local authority home care staff	Assembly Government, LGDU, CSSIW, LAs	Satisfactory
Private or third sector provided, local authority contracted	Domiciliary care agencies of varying sizes, national charities, other third sector providers	Assembly Government, LGDU, CSSIW, LAs	Limited
Private or third sector provided, independently contracted		Individual agencies	Poor
Directly employed, on the basis of devolved local authority budget e.g. direct payment	Personal assistants, domiciliary care agencies	Assembly Government, LGDU, LAs, individual agencies	Limited
Ad hoc privately-paid	Domiciliary care agencies, personal assistants, self-employed domestic help	Individual agencies	Poor
Family / personal (paid and unpaid)	Carers	Carers UK, Census	Poor

[15] The survey elicited responses from 129 service providers. This information came from preliminary work, and should accordingly be treated with caution.

Care and Social Services Inspectorate for Wales

On 31st March 2009 there were a total of 354 domiciliary care agencies registered with CSSIW compared to 340 in 2007 which represents a 4% increase in agencies (CSSIW, 2009). The provider type data indicates a small increase in independent sector providers (1%) and independent provision is currently operating at 87% and local authority at 13%. These percentages do not reflect the actual level of service delivered by the public sector as CSSIW only records the size of the agency and not the overall extent of the provision. There has also been an increase in the number of domiciliary care agencies providing in excess of 200 hours personal care per week. Overall, there is evidence that the regulations and national minimum standards are firmly embedded in practice with fewer requirements made in 2008 and evidence of improvements particularly in relation to:

- Consistency in care planning and clarity about the way in which a service is to be delivered to the individual service user;
- Reviews of the service delivery plan;
- Procedures for administration, recording, handling and disposal of medication;
- Moving and handling risk assessments.

Over 90% of providers have appropriate quality assurance systems in place that meet requirements and there has been an improvement in how the views of service users and their relatives are incorporated. Workforce issues present a more positive picture this year with:

- An increase in the proportion of managers who have achieved the appropriate qualification;
- Less requirements made relating to staff having the competencies to carry out their work;
- A significant increase in the level of supervision being undertaken.

Welsh Assembly Government[16]

The latest annual publication from the Local Government Data Unit (LGDU) (2009) reported that Wales spends £1.3billion on personal social services. The largest proportion of that money was spent on older people (i.e. those over 65) accounting for £474,113m. In addition the document provides useful information on staff directly employed by local authority social services departments – but does not include staff working for independent sector organisations that are providing services under contracts. Key data at 31st March 2008 include the following:

- The total whole-time equivalent (WTE) number of staff directly employed by social service departments was 20,241, a decrease of 1% compared to 2007;
- Home care staff made up 22% of the WTE of the social services workforce. There are the 6,857 home care staff employed in Wales of whom 5,755 work part-time. These staff equate to a WTE of 4,455;
- The overall proportion of home care staff holding a required or recommended qualification was 48%, compared to 44% in 2007;
- 14% of home care staff are reported as Welsh speakers, and able to conduct their work through the medium of Welsh.

More recently the National Statistics First Release (Statistics for Wales, 2009b) summarised information on assessments and social services provided to people aged 18 and over by Welsh local authorities or on their behalf by commissioned independent (private and/or third sector) agencies. The latest release presented key results for Wales for the period 1st April 2008 to 31st March 2009:

- Local authorities assessed the needs of 90,700 people;
- At 31st March 2009 there were 81,500 adults receiving social services. 67,400 people (83%) were receiving community based services and 14,100 (17%) were in care homes;
- Almost three-quarters (73%) of people receiving services were older people, aged 65 or over. Nine in ten users under 65 years old received community-based services compared to 72% for those aged 85 or over;

[16] Tables A5.1-A5.6 in Appendix 5 provide more information and detail on these data.

- People with physical and sensory disability/ frailty accounted for 74% of clients;
- During a sample week in September 2008, 23,600 people received home care. This is a fall of 4% compared to the previous year, with the largest decrease in the number of people receiving less than five hours of care;
- During the whole of 2008-9, 25,685 people received home care;
- The total of home care hours provided by local authorities in 2008-09 decreased by 4% to 11.7 million hours – 56% of these hours were supplied under contract by the independent sector, and consequently 44% by the public sector.

Census 2001 and Carers UK

The 2001 Census collected information regarding the numbers of carers in the UK and the amount of caring they do for the first time. Based on returns, Carers UK recorded that there are nearly 6 million carers in the UK, with 340,745 in Wales – equivalent to 11% of the Welsh population. It is possible to analyse these figures and make an evidence-based judgement about the proportion of care in Wales that is paid for, and the amount that is unpaid provided by carers. Subject to a number of caveats but based on these data and using the most conservative estimates (i.e. the minimum values in the range) the analysis[17] shows that at least 288.5 million hours of care were provided by unpaid carers in Wales in 2001. When compared with the most recent data that 11.7 million annual hours were provided by local authorities (including services commissioned and delivered by others), this demonstrates that a hugely significant 96% of annual care hours in Wales are provided by unpaid carers, with the remaining 4% provided by local authorities and independent providers. This is a much greater proportion than reported in '*Fulfilled Lives, Supportive Communities*' which states that '*at least seventy per cent of the care for vulnerable people is provided by family, friends and neighbours*'.

United Kingdom Home Care Association

UKHCA is the representative association for organisations that provide domiciliary care, home nursing and allied services. In its most recent '*Overview of the Domiciliary Care Sector*' (UKHCA, 2010) it notes that '*in 2001 there were an estimated 6,000 homecare workers in the independent sector*' and that '*since then very little information has been collected on the independent sector homecare workforce in Wales*'.[18] In 2001, 44% of services were provided by the independent sector, and this proportion has grown to 56%. Based therefore on these data and on the proportion of staff to hours of care delivered it is possible to extrapolate the numbers of workers in the independent sector to 8,727 – giving for the purposes of this report an estimated 15,584 workers across the independent and public sector agencies.

[17] Detailed in Tables A5.7, A5.8 and A5.9 in Appendix 5.

[18] They cite the following report as evidence of the estimate figure, but note that the document is not available to download: UKHCA, CCETWS and TOPSS (2001) Next steps: non-statutory domiciliary care providers in Wales, main findings

SECTION 2 | Research Findings

This Section summarises the primary evidence alongside notable practice and secondary evidence gathered through the course of the study and aims to answer the second key question: what is the vision for care at home and its workforce? At the outset of this phase the research team engaged with a range of stakeholders during a Workforce Visioning Event (described in Section 2.1 and Appendix 6). Emanating from that event were a number of key themes for detailed consideration:

- Independence and choice for service users (Section 2.2);
- Provision across boundaries (Section 2.3);
- Role of families and communities (Section 2.4);
- Outcome-focused working (Section 2.5).

Information on these themes was gathered through interview, discussion groups and questionnaires with service users, carers, frontline care workers, supervisors, and managers. This was collated and presented for debate in four themed Deliberative Workshops, summary outcomes from which are presented at Appendix 7. Ahead of the detail which follows, Box 1 summarises below a number of the key issues that set the agenda for this part of the project.

Box 1

Issues that were to be addressed in the primary research phase

Internal forces directing and controlling the pace of development in the sector:

- Recruitment and retention issues;
- Maintaining a trained/skilled workforce;
- Provision of out of hours management cover;
- Rota cover issues;
- Electronic systems in place to support domiciliary care i.e. roster and monitoring;
- Commissioning competencies;
- Quality assurance mechanisms and systems;
- Specialist provision of care versus mainstream care provision.

External forces directing and controlling the pace of development in the sector:

- Expectations of local councils and those of local commissioners of services;
- CSSIW requirements and local Contract Monitoring systems;
- Language, gender, age preferences of service users.
- Influence and impact of inter-agency relationships i.e. community nursing, GPs, pharmacists, private sector domiciliary agencies;
- The 'agency' of service users as commissioners and co-producers of outcomes;
- Information provided for/to service users and service user involvement.

2.1 | VISIONING THE FUTURE CARE AT HOME WORKFORCE

2.1.1 POSSIBLE SCENARIOS

It is difficult to ascertain what impact the White Papers following the consultations on '*Shaping the Future of Care Together*' and '*Paying for Care in Wales*' will have when published. The relevance of their contribution has been underscored by both the Audit Commission's (2010) local government report which bluntly noted that tackling the financial challenge has left councils '*under pressure*', and the Auditor General for Wales who recently argued that '*public services are facing their biggest challenge for at least a generation*' (Wales Audit Office, 2010).

There is the potential for a series of alternative responses and distinct possible future scenarios to emerge in response to these challenges and there have been a number of recent attempts to discern the future shape of social care (and care at home by extension). There is a degree of commonality about these analyses in that they all agree that the *status quo* is unsustainable. In one such document the Department of Health (2010) provided four powerful messages for the future:

1. **Doing nothing is not an option;**
2. **A strategic shift to prevention has the potential to contribute significantly to this agenda;**
3. **Retrenchment (i.e. raising eligibility thresholds) without transformational change is unlikely to deliver the efficiencies that are required;**
4. **Greater efficiencies are much more likely to be delivered through health and social care pulling together rather than pulling apart.**

This analysis drew heavily from the data produced by the Personal Social Services Research Unit's (2009) national evaluation of the Partnerships for Older People Projects (POPP). Their research, and the experience of the projects on which it was based, was wide ranging but starkly made the case that the shift to preventative social care services would not only have outcome benefits for older people but financial savings too. Their data pointed to the fact that an additional £1 spent on POPP services produced approximately a £1.20 saving on bed days as emergency hospital admissions had been reduced due to the shift to prevention.

So, prevention may well come to characterise the future shape of social care in a way that it has not done so to date. What of the role for the service user and citizen in this? The National Endowment for Science, Technology and the Arts produced a recent discussion paper entitled '*The Human Factor*' (Bunt and Harris, 2009). Ostensibly concerned with the NHS (but with considerable linkages to debates in social care) they argued – in line with the Department of Health – that for the kinds of required savings to be realised radical patient-centred service design is required. They stated that whilst efficiencies within the system are necessary they will not be sufficient to restore balance in the public finances, and that radical redesign and behaviour change could bring about much greater savings. This analysis focused on the patient-clinician dynamic and suggested that '*business as usual*' cannot deliver the necessary changes – a fundamental rethink of the relationship is required. They proposed a system of '*people-powered public services*' based on a reconnection between front line staff, patients and the public which could be achieved through creating social enterprises to deliver new services and supporting community groups to drive behaviour change.

One noteworthy contribution in this debate in Wales has been made by the Welsh Council for Voluntary Action (WCVA, 2010). Their paper '*Public services: co-design, co-delivery*' posits that rather than just slicing our existing budgetary '*cake*':

> *…there could be an alternative way of developing future public services which creates a bigger 'cake' and which deploys not just public sector staff and budgets, but also users, families, neighbours, local third sector organisations and the wider community in a 'total service' which goes beyond traditional service provision and releases new resources, skills and energies. It means commissioned services and self-organised support complementing each other rather than operating in isolation.*

The '*co-design*' and/or '*co-delivery*' of public services WCVA advocated would therefore provide a very different formulation for the relationship between the '*formal*' and '*informal*' sectors. It would fundamentally challenge the presuppositions that many public services – including those around care at home – are based on, and argue for a different way of viewing the connection between, for example, commissioners, workers, service users and communities.

Finally, and specifically focused on care at home, Counsel and Care and Ceretas (2009) produced a paper on the basis of a roundtable discussion which provided an analysis of the future of homecare in relation to older people. The implications of their analysis are much broader than for just this group of people, and they suggested that the future should be based on a series of core principles that would underpin commissioning and the provision of care:

- Along with the rest of social care reform, homecare must be provided fairly and transparently, with a fair charging system in place within every local authority;
- Homecare services need to be flexible, in order to meet the increasingly diverse needs of older people using them;
- The personalisation and choice agenda must be balanced with safeguarding so that the safety of older people receiving care in their own homes is not compromised;
- More time should be allowed for each visit – so that the older person is not left feeling at best frustrated and at worst violated when the care worker leaves;

- Homecare workers need to be highly trained and carry out their work in a professional manner. They must take pride in their work and always place the needs of the person they are caring for first;
- Homecare workers should be salaried where appropriate, or be paid an hourly rate to ensure flexibility for those using personal budgets;
- Homecare must be accessible to all older people who need, it regardless of their status; and
- Homecare should be commissioned taking an '*outcomes approach*', and not just a cost approach, to ensure that older people get the care they expect and the results they need from it – that is, independence, choice and control.

There are some potentially far-reaching consequences of all of this thinking for service models in Wales. Whilst it is too early to be certain about the Welsh position regarding '*paying for care*' it is certain that financial pressures from 2011 will require some radical thinking in order to ensure that services can continue to be delivered effectively. This is an issue that will be returned to – suffice to say here that the status quo is the least possible scenario, and a greater role for prevention, self directed care and co-produced outcomes seems very likely.

2.1.2 VISIONING THE FUTURE WORKFORCE IN WALES

In order to make sense of some of these challenges and understand the vision for the care at home workforce in Wales in more detail, the research team organised a Workforce Visioning Event (held in April 2009) at which nearly 50 stakeholders participated in discussions. They were asked to consider how three key dimensions in particular would impact on the recruitment, induction, training, supervision and retention of care at home workers:[19]

- changes in demand (e.g. demography, changes in expectations and resources);
- changes in supply (e.g. skills, qualifications, telecare/other technology); and
- changes in policy (e.g. attitudes toward regulation and commissioning, the structure of health and social care services).

During the course of deliberations it became clear that key themes were emerging, all of which had workforce implications. Some of these were identified on the day, but understandably the debate stopped short of being able to fully comprehend all the relationships, their timelines and their consequences. The main outcome was the identification of the six principal themes which have been used throughout the study (see Table 2 below, split across two pages):

1. Support care at home workers to provide the best care possible, and make dynamic efforts to ensure the long-term sustainability of the workforce;
2. Ensure financial viability of care, by moving towards thinking about where greatest value may be gained;
3. Promote independence and choice for service users, by placing them at the centre of all decisions about their care;
4. Enable continuity of provision across professional boundaries;
5. Recognise and valorise the crucial importance of those in families and communities supporting those in need; and
6. Move towards an outcomes-focused and personalised service for all care provided, regardless of circumstance.

The Workforce Visioning Event provided a constructive platform from which to move the debate forward. It was apparent that two messages (in addition to the six principal themes) emerged with great clarity. Firstly, that many of the issues raised were not new ones, but typically those things left to solve were the difficult ones. Therefore neither the scale of the challenge nor complexity of existing technical, cultural and political circumstances should be underestimated. Secondly, that whilst the implications for the workforce of the changes agreed upon and the vision described were significant, they would not be felt by all sectors equally. Accordingly some of the transformations needed are very specific (focusing on niche client groups for example) and some are universal (applying equally to all care at home workers regardless of job title). Most telling for the way forward therefore was that it was increasingly necessary to think not only of the workforce (as a whole) but of the very distinct workforces, and how these workforces interact with their clients and with their colleagues.

[19] During the discussion, the issues were mapped by the different groups. Appendix 5 presents the detail of the discussions and the implications.

Table 2 | Changes, vision and implications for the care at home workforce

Agreed changes	Visionary statements	Workforce implications / actions
Increasing role of family and other forms of care	Recognise and valorise the crucial importance of those in families and communities supporting those in need	1 Vulnerability of some clients, when PAs are unexpectedly unavailable (through sickness etc), or clients find employing their PA too difficult – leading to the need for 'safety nets' 2 Family, carers and broader social networks will require training and development if they are to play their role to their full potential – for example putting in informal networks and/or befriending services
The value/quality of services for carers and users		
Support for carers		
Support to build social networks		
Maintain quantity, compromise quality?	Move towards an outcomes-focused and personalised service for all care provided, regardless of circumstance	1 Monitor and manage budgets of care, especially if the client receives direct payments 2 Central hub for all information is needed, with appropriate data protection safeguards 3 Consider whether all the elements of care, the outcomes-focused care plan, and a continuous case worker can come from one organisation 4 Enormous cultural and competence challenge for workers at all levels (commissioners, assessors, care planners, managers and care providers) to move to an outcomes-focus
Demand measured by outcomes for people		
More appropriately targeted care		
Personal budgets		
Individual budgets		
Outcomes-focus		
Defining responsibilities in relation to finance	Ensure financial viability of care, by moving towards thinking about where greatest value may be gained	1 Development of innovative approaches by 'agencies' (from all sectors) as they compete for clients, and seek ways of ensuring client involvement in recruitment and appraisal etc
Benchmarking finance		
Continued dominance of a crude 'savings' agenda		
Continuation of funding perversities		

Table 2 (continued) | Changes, vision and implications for the care at home workforce

Agreed changes	Visionary statements	Workforce implications / actions
More co-operation in delivering health/social care Reconciling health/social care skills overlap Reflect status of workers in terms and conditions Continuation of low pay, low value	**Enable continuity of provision across professional boundaries**	1 Cultural change to delivering services across health / social care 2 Train health staff to care for people with people with special care needs, for example those with learning disabilities
Improved training opportunities Flexible workforce – change in tasks undertaken Age demographics, declining workforce Enough workers Benchmark qualifications and accreditation Increase in EU regulation	**Support care at home workers to provide the best care possible, and make dynamic efforts to ensure the long-term sustainability of the workforce**	1 Reduction in some workforce shortages, as new workers are brought in to respond to different types of demand (e.g. shorter hours) 2 Risk of reducing the training of workers (as clients may not pay) 3 Growth in a 'shadow economy' of unregistered workers, not declaring earnings etc 4 Having the right CPD and career options in place to allow workers to feel that they can make the next steps in working with families like this 5 Increase knowledge and skills to deliver 'thinking' generic care – workers able to undertake assessments and make judgments in respect of care delivery 6 Need for "bite-sized" qualifications to accredit additional competences as these are acquired (alongside "role-sized" qualifications
Identify career pathways and re-skilling possibilities Autonomy of service user, independence for users Person centred, self directed support Respond to cultural diversity in clients and workers Increase in male domiciliary workers	**Promote independence and choice for service users, by placing them at the centre of all decisions about their care**	1 Ensure that as soon as is safe and viable, decisions are taken by service users, wherever this is desired 2 Some difficulty in recruitment for some clients 3 Care providers will need to act as coaches/mentors to clients and have the competences to do so

2.1.3 CHALLENGES IN DELIVERING THE VISION

Building on the discussion at the Visioning Event two of the key dimensions underpinning the future for care at home were identified as the relationship between commissioners and providers, and the potential role of the registration and regulation of the care at home workforce.

Commissioning

The Low Pay Commission's (2009) latest report on the National Minimum Wage recommended that '*the commissioning policies of local authorities and the NHS should reflect the actual costs of care, including the National Minimum Wage*'. This was discussed at length during the course of the study – the principal issue being that provider agencies across all sectors are either enabled or constrained by commissioning processes. Whilst there is good practice in some places, there are areas in Wales where the relationship between commissioners and providers is such that there are real challenges in being able to deliver uniformly high quality services to citizens.

The current system in Wales means that independent sector providers (either in the private or third sector) are either wholly or heavily dependent upon local authority contracts for their business continuity and sustainability. Whilst in some authorities there are collaborative discussions between commissioners and providers, such discussions are not universal. Without such discussions there are constraints on the ability of providers to plan effectively for workforce demands and changes. The management of commissioning – either in the relationship between in-house and out-sourced provision, or the management across different client groups – also varies across the 22 local authorities which can result in challenges for maintaining appropriate skill sets within the workforce to deliver care as needed. This is an especial challenge for agencies and providers working across local authority boundaries and/or client groups. The nature of the contracts offered to independent sector providers can also prove to be a barrier to the continuity of care. For example, staff without guaranteed contracted hours are much more likely to look for alternative employment which can impact negatively on the sense of service continuity provided to citizens.

All of this has been compounded by the tightening of local authority budgets, which is clearly a process set to continue. Coupled with the retrenchment of threshold entry criteria for social services care and support, it has increasingly been the experience of providers that fee levels have been squeezed. Whilst care at home services clearly should not be exempt from the drive towards greater efficiencies, there are questions over how locally it will be possible to provide more for less, given the differential practices alluded to above. There is a need to develop a more sophisticated and robust way to ensure local market and workforce sustainability and resilience which takes account of the pressures being felt across the whole social care system.

In response to these and a range of other challenges, the Assembly Government (2009a) in its consultation on the '*Fulfilled Lives, Supportive Communities: Commissioning Framework and Guidance*' proposed thirteen standards against which future commissioning in Wales should be judged. It remains to be seen to what extent these will be reflected in a revised document post-consultation and to what extent these will resolve some of the issues identified above:

> Standard 1 Social Services can demonstrate how commissioning plans have translated their commitments in local strategic plans into consistent high quality linked or seamless services to meet the needs of local citizens;
>
> Standard 2 Commissioning plans have been based upon sound evidence and reflect national policy and guidance, local strategic plans, research and best practice. They include comprehensive population needs, service, market and resource analyses;
>
> Standard 3 Commissioning plans have clearly specified the outcomes to be achieved for service users, and what services will best deliver those outcomes over time;
>
> Standard 4 Commissioning plans have been developed with partners whenever possible and have involved all key stakeholders including service providers, users, carers and citizens;
>
> Standard 5 Collaborative options have been explored for securing directly provided and contracted care services with partners, including health services and other local authorities;
>
> Standard 6 Directly provided and contracted social care services are citizen centred and meet all of the local authority's service quality and human rights commitments;
>
> Standard 7 The local authority has ensured that its Financial and Contract Standing Orders allow social care commissioners to be efficient and effective in developing the local social care market;

Standard 8 Directly provided and contracted social care services have been developed in line with commissioning plans and associated procurement and business plans;

Standard 9 Directly provided and contracted social care services offer value for money;

Standard 10 Commissioners have understood the costs of directly provided and contracted social care services and have acted in a way to promote service sustainability;

Standard 11 Commissioning plans, procurement plans and the services they secure have been monitored and evaluated to ensure they deliver the intended outcomes, outputs and can demonstrate continuous improvement;

Standard 12 Social Services work with all their providers, including directly provided services, to identify the key actions necessary to support them in recruiting and retaining managers and staff with the appropriate knowledge and skills to provide services to the required standards;

Standard 13 Commissioners have been suitably trained, qualified and are available in sufficient numbers.

Of crucial importance in ensuring these commissioning standards are delivered against will be the role of the local Director of Social Services. The recently issued '*Statutory Guidance on the Role and Accountabilities of the Director of Social Services*' (Welsh Assembly Government, 2009b) and in particular the requirement for local authorities to engage and discuss plans with providers as set out in both this document and the '*Commissioning Framework and Guidance*' will need to be closely monitored and enforced if necessary by the Assembly Government.

Workforce regulation and registration

In addition to the regulation of agencies – subject to the Domiciliary Care Agencies (Wales) Regulations 2004 and their registration with CSSIW – regulation and registration of the care at home workforce was also discussed at some considerable length. There are both costs and benefits of workforce regulation and registration, and it is important to contextualise the discussion here in the light of these. In 1997, the Better Regulation Task Force (BRTF) was established as an independent advisory group to the UK government whose terms of reference were to '*advise government on action to ensure that regulation and its enforcement are transparent, accountable, proportionate, consistent and targeted.*' The Better Regulation Commission (BRC) and the Risk and Regulation Advisory Council (RRAC) which have superseded the BRTF have all worked to the same remit. In a series of publications (see for example Better Regulation Task Force, 2005; Better Regulation Commission, 2006; Risk and Regulation Advisory Council, 2009), the BRTF, BRC and RRAC have advocated that decisions about regulation need to be based on five principles:

- Proportionality – regulators should only intervene when necessary. Remedies should be appropriate to the risk posed and costs identified and minimised;
- Accountability – regulators must be able to justify decisions and be subject to public scrutiny;
- Consistency – government rules and standards must be joined up and implemented fairly;
- Transparency – regulators should be open and keep regulations simple and user-friendly;
- Targeting – regulation should be focused on the problem and minimise side effects.

In addition each of these principles is tested against a number of questions when comment is made on the quality of existing or proposed regulation:

- Is the regulation necessary?
- Is it affordable?
- Is it fair?
- Is it effective?
- Is it simple to understand and easy to administer?
- Does it command public support?

It was argued throughout this study that regulation and registration offers clear benefits in terms of valuing and professionalising the workforce. There are clearly costs involved in registration too. Care Council has plans to register all managers of domiciliary care services by 1st July 2012, but has not set any of the terms and conditions to date. The Care Standards Act 2000 requires that the Care Council '*make provision for the registration, regulation and training of social care workers*' but as of yet in terms of the broader care at home workforce no dates have been set.

What follows in the Sections hereafter is a detailed exploration of the themes[20] that emerged as above. The analysis tries to understand how important these issues are currently, as well as how important they might be in the future. This is done mainly through reporting the experiences of those receiving care as reported to the researchers and these perspectives are augmented by the outcomes from workshops, discussion groups and interviews with carers, care workers, supervisors and managers. Where appropriate, examples of notable practice are presented in order to provide information about what is currently being delivered.

2.2 | INDEPENDENCE AND CHOICE FOR SERVICE USERS

In considering a range of options for the future of care, Beresford (2008) argued that '*in both domiciliary and residential settings, care has come to be conceived of as a range of basic tasks to support people's daily living in terms of maintenance*' and affirmed that '*the range of tasks has tended over time to be restricted and sometimes divorced from their human associations*'. He concluded that '*the emphasis has been on outcomes rather than processes*' whilst the opportunities '*they offer for communication, social contact and relationship building*' are underplayed. The situation therefore is characterised by '*standardised services, based on economies of care, rather than matching the needs of service users.*' He makes reference to the primary concern of many service users – namely the desire to remain living independent lives in their own home for as long as they can, supported in appropriate ways to enable them as far as possible to retain control over their own lives.

2.2.1 BARRIERS TO INDEPENDENCE AND CHOICE

There are a number of barriers to independence and choice that affect service users and carers. Some barriers are specific to individuals from specific client and demographic groups, whilst others are universal.

Choice of care provider

One issue that arose was in relation to being able to choose care provider. Boyle (2004) suggests that although at the macro level there is greater choice in terms of the numbers of providers, at the micro level of the service user, choice is restricted to the '*negative choice of refusing service providers*'. There has been some evidence of this in the views of service users and carers in this study. While some older respondents felt they had sufficient control over their care package and were involved in the initial care package discussion, for others this was not the case:

> *'I was given a choice of two agencies. I had no information on which to base my decision, so I went with the agency that I knew provided care for a family I knew' (Service user)*

> *'They told me who would be supplying and how much I had to pay. I had a nice girl coming but now they are changing agencies' (Service user)*

Choice also appears to be limited in relation to the support packages being offered by these providers:

> *'We were given suggestions [when doing the care plan] on what was required but we were limited to what social services offered' (Service user)*

> *'The social worker ran through what they felt was required – then the care plan was set up with the agency so we had no input' (Carer)*

> *'[I would like to know] how much care/money is available per client, not just be told "you can have…"' (Carer)*

Boyle (2004) also suggests that there is little choice in terms of which care worker provides care – one interviewee vividly noted that '*if I don't know 'em [sic] I don't let them in*' *(Service user).*

[20] It is important to note that there are four subsequent sections here – independence and choice for service users (Section 2.2), provision across boundaries (Section 2.3), the role of families and communities (Section 2.4), and outcome-focused working (Section 2.5) – which represents a disconnect with the six themes that emerged at the Visioning Event. The reason for the difference is explained by the fact that in discussions after the event it was decided that the other two themes – supporting the workforce to deliver the best care possible, and ensuring the financial viability and sustainability of care – were so important that they had to feature as part of all the other discussions rather than being isolated. Accordingly for example we ran four Deliberative Workshops on the themes as above but made sure that the other two topics were on the agendas for the sessions.

Not being listened to

Some respondents were very happy with the care they received and felt that they were listened to in relation to both decisions about their care packages and the service they received from the care workers: *'They listen to what I need and are very helpful' (Service user)*; *'They are very good, they do what I want for my meals' (Service user)*. However for others this was not apparent:

> *'My care worker writes things down before she goes. I have asked her what's she writing but she says it's none of my business, but if it's about me it is my business. She gets to see what I write when I sign the paper for her' (Service user)*

> *'I had to tell them to rinse her properly when they washed her private parts but they didn't and it caused no end of problems. I even told them she wasn't being washed properly but they just don't listen' (Carer)*

A small number of respondents with learning disabilities noted that they felt their independence was compromised by care workers doing too much for them: *'They take on too much and this stops us being independent' (Service user)*; *'I'd like to learn to cook but my care worker does it' (Service user)*. Another issue that impacts on independence and choice is that some service users and, to an extent, carers are reluctant to complain when things aren't right because they fear the service will be withdrawn or that it will create problems with the care workers.

Lack of flexibility in care packages

The capacity of service users to '*exercise choice and control is central to the concept of independence*' (Parry et al, 2004). Therefore it could be argued that an important component of a care package that promotes independence and choice is flexibility. A study by Francis and Netten (2004) found that service users' perceptions of flexible home care services should include the flexibility to have additional tasks done outside of the care plan and for timings of visits to accommodate changes to the service users' routine. This it was argued was especially important for service users who lived alone. Many respondents reported that care packages were too rigid and this impacted negatively on their independence and choice:

> *'I have asked my care worker to go to the shop for me but if it's not on the care plan it won't get done. What I need is flexible care; when you go shopping you don't think of everything you might need for the next week so why do I have to think of everything a week in advance? What if I don't want a bath every day?' (Service user)*

> *'They come so early. I don't really want to get up at 7am but that's what time they come' (Service user)*

> *'I can't change my bed as I don't have the puff. I'm lucky now as one care worker will do it but most of them won't. They say it's not part of the package' (Service user)*

> *'Service users need more control over the care package, more choice and more control over the timing of visits-particular issues surround getting up and going to bed. Going to bed is a big problem because carers come too early' (Service user)*

One respondent noted that: *'They gave me more help after my operation as I had someone come in to wash and dress me in the morning but I couldn't have help in the night to get undressed. I couldn't do it myself cos it was my arm you see but I had to manage. They said I didn't need it' (Service user)*. Another respondent felt unable to attend his hospital appointments alone but when he requested a care worker he was told it was not necessary: *'I feel scared – I don't like hospitals. I'm afraid I'll get lost and they ask me hard questions that I don't know how to answer. I want someone to come with me but they say I can go on my own' (Service user)*.

In terms of restricting flexibility, the growth of health and safety guidance and the impact for both service users and care workers was explored in the work of Taylor and Donnelly (2006). They acknowledged that such guidance does indeed impinge on service user independence and choice. However they also noted that care at home workers face a variety of hazards in the homes of clients. They concluded that creative approaches were required to meet the wishes of the client while maintaining the health and safety of the worker. A small number of respondents in this study noted that health and safety guidance could have a negative impact on independence and make life difficult for them:

> *'They say they can't take the ventilator into the bathroom but he only wants to use the loo. Health and safety regulations can limit choice and control and make life more difficult for the client' (Carer)*

One family from a minority ethnic group raised the issue of carers respecting the family's wishes with regards to removing their shoes on entering the house: *'We'd prefer them [care worker] to take their shoes off when they come into the house but that's a health and safety issue' (Carer)*. These views are similar to those reported by Meyer et al (2007) who found that '*policy and bureaucratic processes create a barrier to participants receiving the support they need*'.

Lack of signposting

One of the main barriers to independence and choice relates to the lack of information available to both service users and carers. This is an issue that arose in the work undertaken by Percival and Hanson (2005) who also noted that a lack of information about the availability of services was widespread. During the course of collecting data for this study it became apparent that lack of signposting was a big issue particularly for older respondents. On a number of occasions older people approached the researchers requesting where care could be accessed, indicating a great deal of unmet need: *'I would have help, even if I had to pay for it, but I don't know who to ask' (Older person)*.

Signposting of services is therefore vitally important. Parry et al (2004) noted the centrality of home care services in helping older people maintain their independence. Their study also found that it was particularly important that older people received a positive response when contacting services as they were frequently put off pursuing help if the response was negative or ambiguous. Research undertaken by Hubert (2006) found that lack of signposting was a big issue for families affected by learning disability. Hubert's study also found that many families '*remained independent of external services, only coming to attention in times of crisis*'. This conclusion corresponds with this study which found that for many families – and not just those with people with learning disabilities – they only came to the attention of statutory agencies during a crisis:

> *'Signposting is a big issue. Many families have limited knowledge of what's available. They often have no care plan due to limited personal care needs and the family is unaware of help available. Social services often only become involved in times of crisis' (Charity)*

Box 2

Dealing with signposting: a stronger information, advice and advocacy system for older people

Choice and control for older people is at the heart of current change to the adult social care system. Yet the information, advice and advocacy services older people need to remain independent are often limited, come without adequate support, and fail to take their experiences and ideas into account.

What are the problems?

- Getting this information, and then the advice and advocacy that might be necessary to support this, can be difficult. Information in itself is not enough. Older people clearly state that they often need more than 'signposting': they also need guidance and support;
- Older people need to be involved in the development of services to ensure their needs and aspirations are met.

Ways forward

- Involve older people in meaningful ways and ensure their views are fed into decisions on information, advice and advocacy;
- Enable change by building in dedicated officer time so that necessary development work in this area is not neglected;
- Partner with 'not the usual suspects' such as local transport providers to ensure that the whole system is looked at, not just one part in isolation. Continuous dialogue is key to the success of these partnerships;
- Consider what is known already about what older people and carers want/need;
- Establish a common dataset of up-to-date information that older people, carers and staff can access;
- Provide opportunities for frontline staff to learn from each other to support their critical role in giving information and advice to older people;
- Learn from other areas. Many local authority areas are facing similar issues connected with the ageing population;
- Agree on issues to be addressed by listening to older people and linking to opportunities provided by local and national policy.

Before attempting to work in this way it is vital to:

- Invest in processes so that older people have a variety of ways of sharing their views and experiences. This takes time but pays dividends. Using older people's feedback to design ways of working and services around their needs helped to provide perspective and gave priority to issues that would have the greatest impact;
- Persuade local partners that information and advice is not an add-on to the day job. It is the day job. The emphasis on the importance of this in national policy certainly helps this process;
- Understand that partnership working is much more difficult, complex and time-consuming than working in isolation. It involves continuous dialogue and an iterative process of understanding need, developing priorities, and action planning/delivering together;
- Realise that some issues may need to be addressed across all age groups. Work with older people may have to wait until the whole system has been put in order.

Source: Horton C (2009) *Creating a stronger information, advice and advocacy system for older people* Joseph Rowntree Foundation Solutions, York

http://www.jrf.org.uk/sites/files/jrf/information-systems-for-older-people-summary.pdf

Language and cultural barriers

If an individual is unable to communicate their needs this severely impacts upon their independence. This issue was noted by Hubert (2006) who stated that families from Black and Minority Ethnic (BME) communities are often unable to '*initiate contact, respond or communicate with support agencies*' due to such barriers. Findings from this study echo this conclusion: *'services are not delivered in an appropriate language – when you have a review or assessment then an interpreter is present, but day to day that's not available' (Charity)*. In addition a lack of cultural understanding was felt to be a barrier to families from BME communities seeking support:

> *'Care workers need specific training on cultural awareness. We've had care workers ask when we celebrate our Christmas, one even entered the house eating pork and we don't eat pork for religious reasons' (Carer)*

Such barriers are not just restricted to service users and carers from BME communities. A small number of respondents with dual sensory impairments in this study also noted that for them communication was an also issue: '*considering my lack of sight and hearing, carers need some communication training and basic British sign language*' *(Service user)*.

Specifically in terms of the Welsh language, the Care Council's '*Different Words, Different Worlds?*' (Davies, 2007) acknowledged that '*one bench mark of a modern devolved Wales is that the people of Wales who speak Welsh can live their lives naturally and without difficulty in their own language*'. Further the '*Rural Health Plan*' (Welsh Assembly Government, 2009d) reported that the correlation between community structure, service provision and Welsh language are crucial in rural areas as they have the highest number of people where Welsh is the first language. These factors require the development of workforce strategies which need to consider the specific requirements of communities in terms of both clinical and language skills if true equality of provision is to be achieved. The Plan recognises that such an approach might include '*home-grown*' approaches to the future caring professions.

Research with care workers in this study in Welsh-speaking communities revealed that this was not always the case – they pointed to two types of situation wherein services users were disadvantaged because of problems with bilingualism, contravening the expectation clearly alluded to in '*Fulfilled Lives, Supportive Communities*'. Firstly, there are times when monoglot service users are disempowered and excluded from their care by workers who use a language with which they are unfamiliar. Whilst this rarely occurs for those whose first language is Welsh (and who have limited English) it happens more frequently for English speaking service users who cannot understand Welsh. Secondly, for care workers who have conversational Welsh (but who struggle with specific vocabulary) there is a real barrier to effective service delivery if care plans and service delivery plans are written in Welsh. Whilst not widespread there were reported incidents that this occurred which clearly impacted on the way in which care could be delivered and by extension constrained the independence of service users.[21]

2.2.2 ENABLERS FOR INDEPENDENCE AND CHOICE

Despite the barriers noted above there are a number of features of care at home services that enable service users and carers to have greater independence and choice.

Personalisation

According to Carr (2008) personalisation means '*starting with the individual as a person with strengths and preferences who may have a network of support and resources, which can include family and friends and they may have their own funding sources or be eligible for state funding*'. Personalisation reinforces the idea the individual is best placed to know what they need and how those needs can be best met. It means that people can be responsible for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so. In this way services should respond to the individual instead of the person having to fit with the service.

[21] Despite offering to conduct interviews with service users in the medium of Welsh, organisations approached to help in Ceredigion and Gwynedd were unable to link the research team directly with Welsh-speaking service users. When conducting interviews with service users in other parts of Wales the issue of receiving services in the Welsh language was not been raised directly by participants. That said, and as acknowledged above, there remain real challenges in delivering services in the language of choice to everyone across Wales.

This traditional service-led approach has often meant that people have not received the right support for their circumstances or been able to help shape the kind of help they need. In short, personalisation is about giving people much more choice and control over their lives.

Personalisation itself is therefore not necessarily a new idea. It applies to everyone regardless of their needs and includes those who may not be entitled to publicly funded care. The case for personalised services was clearly made by Demos (Leadbeater, Bartlett and Gallagher, 2008) in their publication '*Making it Personal*'. They advocated that '*self-directed services*' which allocate people budgets so they can shape, with the advice of professionals, the support and services they need should become the cornerstone of public service delivery. However, personalisation is a relatively new term and there are different ideas about what it could mean and how it might work in practice. Amongst others, there are several terms typically used in association with personalisation:[22]

- Person-centred planning focuses on supporting individuals to live as independently as possible and giving them choice and control over the services they use. Rather than fitting people to services, person-centred planning recognises that services should fit the person;
- Person-centred care has the same meaning as person-centred planning, but is more commonly used in the field of services for older people;
- Person-centred support is a term being used by some service user groups to describe personalisation;
- Independent living is one of the goals of personalisation. It does not mean living on your own or doing things alone, but rather it means having choice and control over the assistance and/or equipment needed to go about your daily life;
- Self-directed support is a term that originated with the in Control project and relates to a variety of approaches to creating personalised social care. In Control sees self-directed support as the route to achieving independent living;
- Co-production is a fairly recent term that is used as a new way of talking about direct participation and community involvement in social care services in the UK. It has also been called '*co-creation*' and can be seen as a way of building social capital. Research on co-production has shown that frontline workers should focus on people's abilities rather than seeing them as problems (Boyle et al, 2006) and should have the right skills to do this. Co-production should mean more power and resources being shared with people on the front line – service users, carers and frontline workers – so they are empowered to co-produce their own solutions to the difficulties they are best placed to know about.

Much of this is self-evident and is being delivered as part of good practice. As Glynn et al (2008) argued: '*person-centred support is not another thing services have to do; it's what they must do. It's not another job – it's the job*'. Indeed for some service users in Wales – primarily those with learning disabilities – personalised care has been a reality for some considerable time.

Whilst personalisation encompasses much more than the payments systems underpinning it, these mechanisms are a central part of the agenda. Commonly, personalised services are currently paid for with direct payments, personal budgets and individual budgets:

- Direct payments are means-tested cash payments made in the place of regular social service provision to an individual who has been assessed as needing support. Following a financial assessment, those eligible can choose to take a direct payment and arrange for their own support instead. The money included in a direct payment only applies to social services;
- Originally, the term personal budget only applied to social care funding but now it is often used interchangeably with individual budget. It is the funding given to someone after they have been assessed which should meet their needs. They can have the money as a direct payment or can choose to manage it in different ways, like through Individual Services Funds (ISFs). What is important is that these budgets give people a transparent allocation of money and the right to choose how this is managed and spent;
- Unlike direct payments, an Individual Budget (IB) sets an overall budget for a range of services, not just from social care, from which the individual may choose to receive as cash or services or a mixture of both. IBs combine resources from the different funding streams to which an assessed individual is entitled. IBs aim to align assessments from the different funding streams, encourage self-assessment (where appropriate) and introduce transparent resource allocation systems (RAS), so an individual knows exactly what resources are included in their IB.

Self-directed support

As noted above much of the current personalisation policy has been influenced by the practical work of in Control, established as a social enterprise in 2003, which has pioneered the use of self-directed support (SDS) and personal budgets as a way to reform the current social care system. As they note, SDS is a new system which is about people being in control of the support they need to live their life as they choose. Written for service users their guide identifies seven stages in SDS:

Box 3

How can you use person centred information to drive strategic change and commissioning?

Working together for change (Department of Health, 2009a) describes a simple six-stage process that uses person centred information (for example from person centred reviews, person centred plans or support plans) to drive strategic change and commissioning. Working together for change is a structured approach to engagement with people using services to review their experiences and determine their priorities for change. It is a systematic process for planning change with people, which provides powerful insights into what is working and not working in their lives as well as their aspirations for the future. It can be used to ensure that co-production with local people and families is at the heart of social care transformation programmes, as a vehicle to improve community engagement in the Joint Strategic Needs Assessment and as a tool for strategic commissioning.

The six stages are:

1. Gathering the person-centred information – e.g. from individual outcomes-focused reviews;
2. Transferring the information into a usable format – involves transferring statements to individual cards which captures the top three things that are working and not working in people's lives and the three things most important to them for the future;
3. Clustering the information into agreed themes – this happens during the course of a full-day workshop and includes naming each cluster with a first-person statement to best describe the theme of the information;
4. Analysing the information – this also happens during the workshop and includes analysis of possible root causes for things that aren't working in people's lives and a consideration of what success might look like if people's aspirations for the future were realised;
5. Action planning – conducted on the basis of the clustering and analysis, different stakeholders plan what they will do differently;
6. Sharing information – information about the process is shared with others, particularly the actions that have resulted The process should be conducted cyclically – perhaps annually, so that the impact of previous action is understood, further actions can be taken to change the things that are not working for people and people's aspirations for the future can continue to drive local strategy and commissioning.

Source:
http://www.dhcarenetworks.org.uk/_library/Resources/Personalisation/Personalisation_advice/WTFC_Final.pdf

[22] SCIE has produced a helpful set of guides as to the implications of personalisation for a number of groups – among other document these are available from http://www.scie.org.uk/adults/personalisationpub.asp.

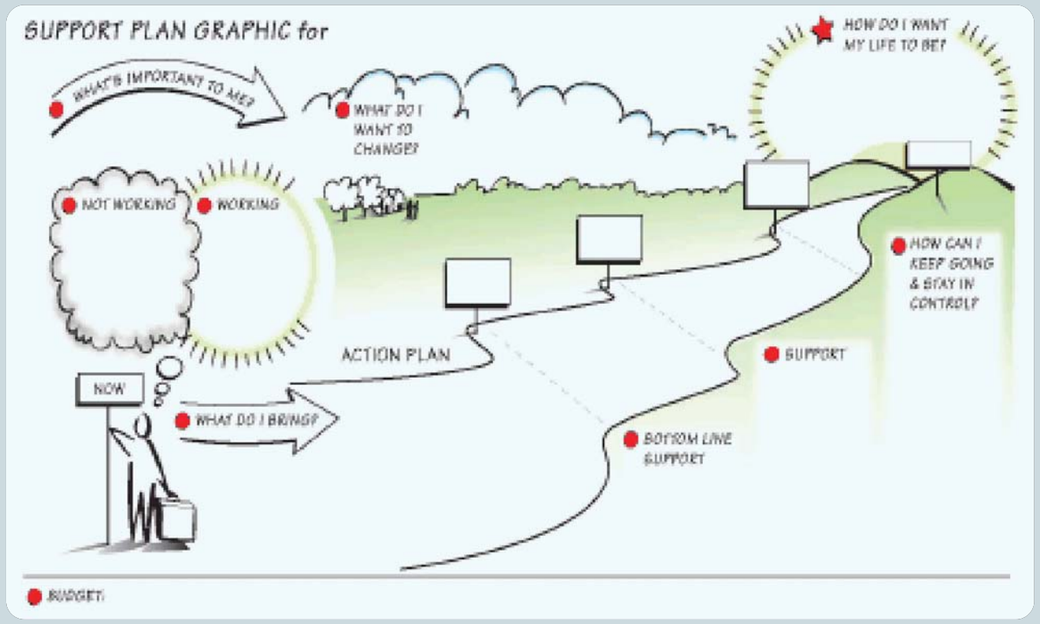
1. My money – finding out how much. The first thing to do is to find you if you can get money for support - and how much;
2. Making my support plan. The second thing is to make a plan about how you'll use the money to get the life you want. You can do the plan yourself. You can have help to do it - as much as you want;
3. Getting my plan agreed. A care manager at the council has to agree your plan;
4. Organising my money. You can have the money paid to your or to someone who can look after it for you (a person, a Trust, an organisation or the care manager);
5. Organising my support. You can organise the support in a way that suits you. You can get help to find and organise support;
6. Living life. You can use services but you can also spend your money on local people who you know - or even buy things that will help you in your life;
7. Seeing how it worked. You have to show that you used the money properly.

Building on this, research undertaken by Spandler and Vick (2006) found that direct payments (as part of an overall SDS approach) can help promote social inclusion and participation. A small number of service users and carers in this research were in receipt of direct payments and individual budgets:

Box 4

Making a support plan

The graphic below might be useful in thinking about making support plans:



Source:

Helena Taylor Knox (2009) Personalisation and individual budgets: challenge or opportunity HQN Associates, York http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/HQN_personalisation_and_individual_budgets_.pdf

[23] Individual Budgets in social care have been subject to a recent national evaluation – for information see Glendinning et al (2008b).

'Direct payments and individual budgets are a way of getting more control. I use my money to pay for my own respite. Although there are restrictions on the way people spend their money' (Service user)

'The care plan for the direct payments covers everything you can think of. They have done it with [daughter]. We're hoping this gives [daughter] more control as she will choose who will take care of her' (Carer)

'We have had the same care worker for ten years. Our daughter has one-to-one care and the Independent Living Fund funds a small team. They wash her and take her out, she likes to go dancing but we're too old to do that with her, we'd stick out like a sore thumb in those places. She wants to go to places with people her own age and her carers are young, well they are compared to us, so that's nice. She also goes swimming now with one of the carers' (Carers)

It is evident that SDS can facilitate independence and choice for service users as they are able to choose the care that is most appropriate to their needs. This is supported by existing research undertaken by Blyth and Gardener (2007) which noted that direct payments offer families the ability to arrange flexible support that meets the needs of both the service user and their family.

Box 5

The Collaborative Self-managed Care Project (CSCP): developing mutual models for self-managed care using Direct Payments – Co-Operatives UK, Mutual Advantage and the Department of Health

CSCP Aims

To increase the take-up of direct payments by under-represented groups, by developing a co-operative or social enterprise approach, which gives service users greater control over their care, promotes good employment practice and delivers good quality care and value for money. The project aims to support the achievement of the Department of Health's Priority 4 – 'Older people & Disability: Support the extension of direct payments and the development and use of individual budgets including ensuring their take up by under-represented groups'. The project was initiated to address the particularly low take up of direct payments by older people, and:

1. To develop collaborative models for direct payments, including operational, governance, constitutional and legal arrangements, and evaluate pathways;
2. To prepare a model set of systems, standards and processes to assist the new organisations to achieve the National Minimum Standards and achieve registration with CSCI, under the Care Standards Act;
3. To support and evaluate four pilot projects;
4. To offer an initial advice and support service to VCS, groups of direct payment users, social enterprise support organisations and local authorities; and
5. To develop a networking infrastructure; and
6. To evaluate the pilot projects and disseminate learning.

The pilot projects

- All are co-operatives or social enterprises, who run finance and administration;
- Stakeholder led, balancing service users, staff and carers;
- Flexible services with users controlling their own day to day care;
- Registered with the Care Quality Commission;
- Care staff are employees; all committed to service model.

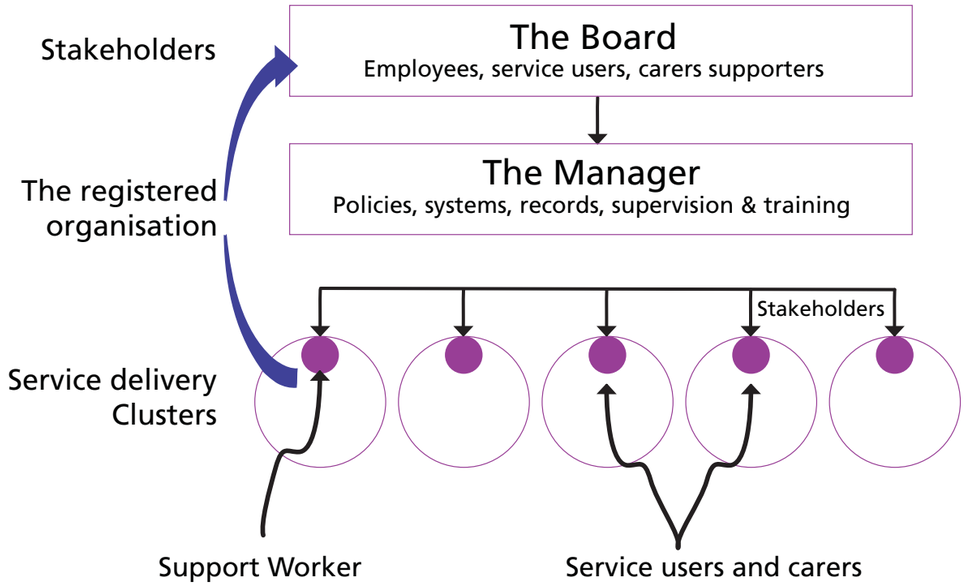
How the pilots will operate – clusters and structure

- A cluster is a group of service users and staff working together in a locality or around a "theme";
- Each cluster may have perhaps 15 service users and 150 care hours per week;
- Each cluster has a single part time Support Worker who looks after both staff and service users;
- Five or six clusters form the organisation which has a manager.

Source: **http://cscp.webeden.co.uk/**

Diagram on the next page

Box 5 b



Personal Assistants (PAs)

UK research on direct payments (Priestly et al 2007) and the Individual Budget evaluation study (Glendinning et al, 2008b) found that many people who opt for the IB cash option choose to employ personal assistants (PAs) – in the IB evaluation over half the sample employed PAs, especially where they were receiving their IB as a direct payment.

For the most part, service users are generally confident about taking on the responsibility of becoming an employer. That said, according to a recent study (IFF Research, 2008) undertaken with more than 500 service user employers (all of whom were in receipt of a direct payment and who used the money to employ a PA) there are sizeable minorities who stated that they find the responsibility of being an employer daunting (27%) and that they find it difficult to cope with the administration of being an employer (31%). Elderly employers are more likely to express these concerns but those who have been receiving direct payments for longer are less likely to agree that they find being an employer daunting.

This suggests perhaps that confidence in these matters comes with experience, and that many of the difficult administrative tasks come at the beginning of a PA's terms of employment. Responses to some of the questions asked about approaches taken to recruitment and employment of PAs also indicate that employers would benefit from more guidance in this area than they are currently getting. Some of these perspectives were reflected in the research undertaken for this project in that despite the flexibility offered by direct payments in particular, some were wary of utilising these options:

> *'Families can be put off by direct payments as they see it as too much effort' (Charity)*

> *'I did it for a while but it's a lot of effort trying to sort out tax and thing on top of everything else. That's what puts carers off' (Carer)*

> *'Although more people are moving towards direct payments it won't be suitable for all client groups. Services will have to be able to provide a much more flexible and mixed market than has been available in the past. Take up of direct payments will increase as people become more familiar with it and more comfortable' (Commissioner/provider)*

> *'We are routinely asking referrals if they have been offered direct payments options and signposting them if they haven't' (Provider)*

> *'Many older people don't want the hassle of organising their own care, or are cautious because they don't understand it. But that will probably change, as future generations will have different expectations of care services' (Provider)*

The IFF Research study goes on to argue that service user employers tend to value personality traits over proven skills and experience when it comes to selecting PAs. However, around one third of PAs feel that they need to develop certain skills in order to become fully proficient in their job role, especially in terms of administering medication, moving and handling, and personal care. Employers are less likely to note these as problem areas, and are generally unwilling to fund training for their employees frequently citing the prohibitively high cost. Funding for training does seem to be the main barrier to training provision, which is linked to the under-funding of support mentioned by a significant number of employers. It may be that access to training for PAs could be improved if extra funding for training were to be included in direct payments employers' support packages. While employers are more likely to state that they would be willing to offer training if grants or subsidies were available, there are still a number who feel that the organisation of training and development is not their responsibility (indicating a failure to fully embrace their role as an employer).

The research also found that the majority of employers questioned felt that having an official register of PAs would be useful, three fifths (58%) saying that it would be very useful. Service user employers are divided evenly between those who feel that, if a register was introduced, registration should be compulsory and those who feel it should be voluntary. Where employers state that registration should be voluntary, the most common reasons given for this view are that PAs should be given freedom to choose whether or not they register and that compulsory registration might put individuals off becoming PAs. Where employers thought that registration should be compulsory, by far the most frequently mentioned reason was that compulsory registration would help to ensure security of employers and allow them to be confident in the suitability of the chosen PA. PAs were even more positive about the concept of registration, and were significantly more likely to think that registration should be compulsory for everyone employed through the direct payments scheme. The vast majority (85%) stated that they are not at all worried about the impact that registration would have on them.

Self financed care

There is currently no data available on the number of service users or carers who self finance their care. Of the respondents spoken to for this study, only three admitted to fully self financing their care. In all these cases social services drew up care plans and assessed the respondents as having to pay for their care. For two respondents self financing their care was more of a barrier than our enabler: '*I pay for my care as my husband works but we can't afford to pay for all the care I need so I just have to have a personal care and manage*' *(Service user)*; '*I've been told I need to pay a £100 per week towards my care because my late husband had a private pension. I can't afford that so I have the minimum amount of care that I can manage with*' *(Service user)*. Despite only a small number of respondents fully self financing their care, this research found that other service users supplement their care package by purchasing additional help:

> *'I have a housekeeper who helps out. I pay for that myself' (Service user)*

> *'I pay someone to do the cleaning and someone does the garden' (Service user)*

> *'We pay for someone to do the washing. They come and collect it and then bring it back' (Service user)*

Other research suggests that some service users prefer to pay for support as it offers them control and reduces the burden of guilt they feel around utilising the support of family and friends: '*co-modifying these relationships made them less problematic and diminished the sense of being dependent on others*' (Parry et al, 2004).

This research found that there were issues of awareness about being able to add to care packages once assessed:

> *'Many clients don't realise that they can top up on the services that are available to them via social services. They can top up their care package by financing additional services privately. It would help if on assessment people are told that "this is the maximum you can have and we will fund, but you can purchase additional services if you would like to." Sometimes there is an assumption that people won't be in a position to pay for additional services and so the offer isn't made – we shouldn't be making that choice for them. They should be given the information and allowed to make the decision themselves' (Provider)*

Having more control over care and support

In line with the evidence proposed by the Joseph Rowntree Foundation's report of the older people's inquiry into '*That Bit of Help*' (Raynes, Clark and Beecham, 2006) carers and service users suggested a number of relatively simple things that would make them feel more in control of care and support services:

> *'Somebody helping me to write a proper care plan' (Service user)*

> *'Professionals who make the decisions to ask for feedback from the service user about the decisions made' (Service user)*

> *'Not having so many different care workers come in – they don't last very long in the job and just as you get to know them they've gone' (Service user)*

Box 6

Telecare, telehealth and its role in independence and choice

Telecare has its roots in social alarms. The latter have proved their worth in helping support mainly older people with lower level support needs in their homes. The development of broadband communications networks and the building in of more intelligence into what were, at one time, simply alarm devices means that there is a great potential to found a new range of domiciliary help, at least in part, on such technologies. This potential embraces telehealth (Fisk, 2003) and already there are substantially growing numbers of people with relatively high levels of support need who are benefiting from the same.

The broader context is that of assistive technologies. Care at home workers will be increasingly familiar with such devices as ranging from weighted cutlery to task lights, bed leavers, bath aids and wheelchairs. They will be becoming more aware of the range of sensors that can now be linked to carephones at the heart of telecare systems and which can send information, via the telephone network, to a monitoring and response centre. What is missing at the moment, however, are consistent frameworks for assessing needs in the context of such technologies in order to underpin support and response protocols. As there are more people (regardless of age) with support needs and living in their own homes, technologies will be taking a greater role. Care needs are supported in a number of ways – through enabling a speedy response (via the use of passive or active devices) in the event of a fall or seizure; or in monitoring activity and medication compliance. Telehealth 'vital signs' monitors are, in addition, now in more widespread use for people with long-term conditions and with whom there is on-line interaction with support staff.

Currently there are some 20 telecare services in Wales serving a probable near 100,000 (mostly older) people. This includes a growing proportion with a dementia. There is, however, a telecare initiative that is delivering to people with learning disabilities pioneered by the Community Lives Consortium in Swansea (see www.communitylives.co.uk). Two of the services in Wales have a mobile response service. Five services, for key elements of their services, are accredited to the Telecare Services Association Code of Practice (see www.telecare.org.uk).

Care at Home: challenges, possibilities and implications for the workforce in Wales

Box 7

Combating a high turnover of staff and ensuring continuity for service users– the Red, Amber, Green (RAG) system

75% of those who decided not to continue their employment with one private sector provider did so within the first six months. To reduce the high wastage of people, time, cost and poor continuity of care, the provider identified that the experience of the early months in the career of a care worker was therefore vital to their longevity – too much work, too soon could overwhelm even the most enthusiastic new care worker and cause them to leave the service.

Thus the provider introduced a Red, Amber, Green (RAG) status for all new recruits that graded people by their experience and capabilities. The process works as follows:

- Every care worker recruit attends a 3-5 day induction programme and their performance on that programme couple with their previous experience enables the training manager or care director to designate them as either Red (no prior experience), Amber (some prior experience), or Green (a lot of prior experience and demonstrated full understanding of the training programme);
- All service users are also categorised as Red, Amber, Green:
  - Red means they have complex care needs and/or are difficult to communicate with;
  - Amber means they have less complex easier needs;
  - Green means that only simple tasks need to be performed and the service users have good communication skills.
- Red status care workers can only work with Green status service users for the first two weeks and then can be reviewed for Amber status clients. During shadowing all status care workers will attend Red and Amber calls and be assessed – the Amber care workers will then be confirmed as experienced enough to handle all status service users or kept to just Amber and Green service users;
- The Red status care workers will not receive a full allocation of work hours – they will be given a light workload to get used to personal care and medication control;
- Amber status is agreed by the care director and the care worker between two and eight weeks post-training according to the ability of the care worker;
- An Amber care worker should spend only 2 weeks at that stage – or even less given that the care director has assessed their performance.

The RAG programme has reduced the wastage of people, improved the quality of care for service users and saved money in recruitment and training cost.

2.2.3 SUMMARY – RESPONSES TO INCREASED USER CHOICE

Bringing the issues presented here together, an analysis by Baxter et al (2008) summarised the possible opportunities and threats posed to domiciliary care agencies of increased user choice:

- Local authorities had recently introduced contracts with independent home care agencies based on geographical zones. With agencies concentrating staff and activities in one locality, personal budget holders' opportunities for choice of agency could be restricted;
- Agency managers anticipated that, as smaller agencies had more personal contact with their clients, they were better prepared for negotiating care arrangements directly with personal budget holders. Larger agencies were expected to be better protected against new financial risks arising from personal budgets, including non-payment of bills;
- Other risks anticipated by home care agency managers included personal budgets being set too low to allow users to purchase agency care, leading to reduced demand for services and the loss of workers to private employment;
- Personal budgets also offered new opportunities for agencies, including opening up new markets and demands for new types of support, such as help with shopping and social activities;
- Agency managers did not have clear strategies for advertising their services to potential personal budget holders;
- Agencies used a range of incentives and controls in both care worker and client contracts to discourage workers from leaving to work privately for a personal budget holder. These may have implications for user choice.

As acknowledged by Baxter at al (2008) the issues around personalisation and the implications for the workforce are not universally positive. A recent Unison study (Land and Himmelweit, 2010) identified a further series of issues to be overcome – especially around the employment of PAs – before many of the burdens associated with increased personalisation had been effectively dealt with. Given that in Wales personalisation is in its relative infancy, there are real opportunities to learn from the experiences of others in order to avoid common problems and challenges. In particular the implications for the workforce of greater choice for service users need to be carefully considered.

2.3 | PROVISION ACROSS BOUNDARIES

2.3.1 SOCIAL CARE AND ITS 'INTERFACES'

Housing

The social care and housing interface has always been blurred on account of the advent of what has more recently been known as '*housing related support*'. At the core of housing support have traditionally been sheltered housing wardens (latterly scheme managers) and, more recently, floating or residential support workers with generic or more focused roles e.g. for people with learning disabilities. Sheltered housing usually provides accommodation for older people though it has its manifestation for others. Its latest incarnation is in '*extra-care*' housing, seen as a potential replacement for residential care – within which people have more spacious accommodation and the rights of tenants rather than licensees. The place of housing support was cemented by the advent of '*Supporting People*' funding. This sought to separate out those tasks that could be deemed property related (and, therefore, legitimately charged for in the rent) as opposed to those that related to a person's support needs.

The context in housing has changed from one initially concerned with specialist forms of accommodation – whether sheltered housing or other forms of '*supported*' housing – to one focusing on people staying in and being supported within their own homes. Some of the tools to enable this are increasingly in place through better building standards, adaptations, the activities of care and repair agencies, and the use of telecare, telehealth, and assistive technologies more broadly. As with healthcare workers, however, we can see different tasks being undertaken by support workers with '*housing*' roots that are important in underpinning personal well-being and, in some instances, health. Hence there are potentially changing roles for mobile and community wardens, floating (and other) support workers, telecare officers and the like.

Health

Current reform and reorganisation in Wales (Jones et al, 2009a) is attempting to bring healthcare practitioners and clinicians closer to the people they serve. As noted in Section 1, Community Resources Teams, for example, will have important implications for care at home workers. It will mean that more and more people – including nurses, podiatrists, opticians, physiotherapists, occupational therapists, pharmacists, healthcare assistants are, and will be, working in people's homes. The divide that saw social care being delivered in the home and healthcare in other settings will blur even more.

This shift brings with it a further array of tasks associated with health and well-being concerned with such matters as exercise, nutrition, social engagement, motivation and medication compliance. The question here is around the extent to which these are (or should be) the exclusive preserve of healthcare workers. There are exciting possibilities for care workers (and social care staff more broadly) to develop their skills in these areas. As care workers themselves acknowledged: '*we should be trained in some health tasks – we'd all be happy to expand our role if there was appropriate remuneration for it*' (front line care worker); '*we are increasingly encroaching in on what health are doing and that's good*' (front line care worker).

All of these issues at the interface are potentially more significant in rural parts of Wales where the cost of duplicating services are increasingly prohibitive. The '*Rural Health Plan*' (Welsh Assembly Government, 2009d) describes the nature of the challenge for such communities, which includes a number of salient issues:

- the interface between NHS and local government provision to rural proofing of all Assembly Government policies;
- the equitable formulae for financing rural health to the establishment of community hospitals, retirement homes, sheltered housing, and pharmaceutical services all on a common campus;
- improved ambulance services to co-operative transport schemes; and
- developing more generic skills among health and social workers, to more humane and reasonable timetables of appointment for rural dwellers.

2.3.2 PROVIDING CARE ACROSS BOUNDARIES – CHALLENGES

When researched, issues with provision across boundaries were raised by service users and carers whose care packages involved elements of medical or health care, or where more than one family member had care needs which were being met by more than one organisation or agency.

Joined-up working?

A number of respondents cited a lack of joined up care as the key issue when it comes to receiving care form different providers across sectoral and organisational boundaries:

> *'Issues can arise around care of more than one family member. I had a case where both the mother and daughter had care packages and there was no co-ordinated care between health and social care. Someone would come in and do breakfast for the daughter, someone else lunch for mum. Shopping was done by another person but they couldn't take the daughter out. All these people and no co-ordinated approach to care as the funding came from different budgets! Some weeks this family had fifteen different care workers and all they needed was one' (Charity)*

> *'This is especially important around issues of hospital discharge but as a principle the system works best when everyone involved in delivering care are able to meet regularly – it goes a long way just to sit and communicate but there are real barriers to involving independent sector providers in this mix' (Provider)*

> *'Training across the health and social care boundary will develop a true sense of one workforce and one sector – specialisms can then follow. The Qualifications and Credit Framework (QCF) offers a real opportunity to remove some of the barriers' (Provider)*

> *'There needs to be better sharing of information between agencies. It's getting better now we are networked with social services so we can make referrals and share information' (Direct Payments Coordinator)*

The challenge of integration

As the Rural Health Plan (Welsh Assembly Government, 2009d) notes, '*central to improving services is the crucial factor of integration. So much waste can be prevented and better care and support provided by eliminating duplication. Integrated service models, workforce planning and systems are necessary to improve future provision and ensure the effective use of all resources and skills within communities. This will necessitate a vastly improved cohesion across organisational/professional and business boundaries and between NHS, local government and third sector services*'. These are issues which clearly go well beyond their application solely to rural areas. In this study, a variety of challenges were identified which explain why services were not as well integrated as service users and carers felt they could be. Issues cited included:

> *'It is important to work closely and develop relationships with third sector and independent sector but there's not as many clinicians on board as needed to progress health and social care working' (Provider)*

> *'There's no consistency across the boundaries. We have nursing care they come in to wash, dress and see to the medical needs in the morning. We then have day and night sitters provided by social services. The nurses won't take [service user] to the bathroom but the afternoon sitters will. The nursing care and night sitting service is provided year round but the day sitting we are not covered for bank holidays or annual leave' (Carer)*

> *'People are so protective of their own organisations; even where partnership working is good … they are worried that they might lose their voice, their jobs, and their authority. The community are crying out to be heard, but organisations are still arguing over whose responsibility is it!' (Provider)*

One of the classic challenges for care workers centres on medication compliance and medication administration.[24] Rather candidly, the issue was acknowledged by a care worker who stated that many care workers end up undertaking tasks that they know they probably shouldn't: '*don't tell me that the vast majority of care workers have ignored people when to do so would put the service user in real difficulties – they might be in need of eye drops when there was no alternative than to administer the medication. Much more needs to be done to sort this out and find a simple common sense solution*' (front line care worker).

Box 8

Resolving data sharing problems: the Wales Accord for the Sharing of Personal Information (WASPI)

The purpose of WASPI is to provide a framework for service-providing organisations directly concerned with the well being of an individual to share information between them in a lawful and intelligent way. It facilitates this by establishing agreed requirements and mechanisms for the exchange of personal information between different partners in a care environment. This is called an "information sharing community". This community can be made up any number of organisations and these can be public sector, voluntary sector and private and independent organisations. There is no limitation as to what organisation can be part of an information sharing community and no limitation to sign up and use the WASPI framework. The WASPI framework is made up of two parts:

- The Accord – the common set of corporate principles and standards under which partner organisations will share information. It records the commitment of each partner organisation to meet agreed standards for the sharing personal identifiable information and to use the framework. It MUST be signed by the Chief Executive or equivalent;
- The Personal Information Sharing Protocol (PISP) – identifies the operational data requirements to be shared for specific and lawful purposes and details:
  - the specific purpose(s) for information sharing ;
  - the group(s) of service users it impacts upon;
  - the relevant legislative powers and the consent processes involved;
  - what data is to be shared;
  - the required operational procedures and the process for review;
  - the means of communicating to practitioners the specific operational requirements;

Essentially this is the "who/why/where/when/what/how" questions of sharing personal information. There will only be one Accord for Wales whilst there will be many PISPs. Although originating in Wales the WASPI framework can easily transfer across to non-Welsh information sharing communities as the concept of principles and delivery will fit most situations.

Source:
http://www.wales.nhs.uk/sites3/home.cfm?orgid=702

Box 9

Principles of working in partnership across health and social care

Although it is very difficult to reduce the complex management of working in collaboration, the following attempts to distil the essence of the task to twelve key and interdependent principles:

1. Collaboration is not a panacea;
2. Clarity of purpose is a fundamental prerequisite;
3. Decide on who does what;
4. Effective collaboration relies on trust;
5. Collaboration needs appropriate leadership;
6. People working in collaboration need the right skills and attributes;
7. There is no substitute for effective governance;
8. Measure success and outcomes;
9. Resourcing is crucial;
10. Delivery is difficult;
11. Engage with the public;
12. Promote learning.

Source: Williams P and Sullivan H (2007) Learning to Collaborate: Lessons in Effective Partnership Working in Health and Social Care NLIAH

Scourfield (2007) examined the impact of changed organisational structures on cultures and practices for health and social care practitioners. He pointed to the issue of integration as '*emotionally charged*'. The key interface issues he identified related to hospital discharges and the prevention of admissions. Difficulties at the interface brought into focus the questions about '*what exactly personal care is and when does health care become social care, for example over assisting with medication, bathing and so on?*' In his study, where integrated teams were in place, the perception was that private agency care services '*did not match up*'.

Where effective provision across boundaries exists there are clear benefits to be derived for service users. This is illustrated by a number of respondents in this study who had access to specialist nurses who worked across boundaries, and further exemplified by the success of the introduction of a multi-disciplinary mental health home treatment team delivering care in the community:

> *'They [specialist nurses] are great. I've been waiting to have a shower installed and a seat for the shower. By the time I came home from hospital she had arranged it all. I then had a phone call off the council saying they would come out and assess my need in a few weeks I told them not to bother it's done. Months I've been waiting for them and she did it while I was in!' (Service user)*

> *'They are great if I phone them up and say I don't feel so good today. Within half an hour a nurse will be with me. She'll do things for me and she gets in touch with other agencies you know if you need a wheelchair or adaptation they will organise it all. If only all services were so quick' (Service user)*

Box 10

Meeting the challenge of medication: the Cardiff Medicines Administration Scheme (CARMAS)

Established originally as a small initiative in Llanishen, North Cardiff, the CARMAS scheme offers an excellent insight into the way in which social care staff work with pharmacists and, therefore, make a contribution to healthcare. The scheme has received some support through the Welsh Assembly Government 'flexibilities special grant' that was directed at initiatives at the health and social care interface.

The service is styled as a 'joint pharmacy and social services scheme designed to promote independence and independent living'. At the core of CARMAS, home care managers of the Council's social services staff make assessments that identify where there is a need for assistance, among their clients, with taking medication. Home care workers provide this assistance after receiving appropriate training from pharmacists. They receive a higher level of pay in recognition of the additional responsibilities.

The stated objective of the service is 'to ensure safe administration of medication to vulnerable people'. Such administration is, of course, undertaken with careful regard to the instructions of the pharmacist – these including necessity for 'accurate and reliable recording of medicines being taken', their safe storage and, where necessary, disposal. A range of guidance sheets set out the processes and required actions for e.g. logging information, re-ordering and dealing with medication errors. 'Administration', it can be noted, includes helping a service user to take medication from a container; or taking it from the container and offering the medication to the service user.

In order to be part of the service, a user must require assistance with managing their prescribed medication, and this requirement must set out within a formal care plan. The needs assessment pro forma used by home care managers when making assessments indicates a range of factors that can affect a user's ability to administer their own medication. These include cognitive impairment, sight loss, a lack of dexterity, poor memory and difficulty swallowing.

There are, of course, some legal restrictions that apply to the extent of health related assistance that home care workers are permitted to provide. The broader context is one, however, where, with some exceptions, any responsible person can administer medication subject to acting in accordance with the directions of a suitably qualified practitioner (i.e. a doctor or dentist). This flexibility is clear in the 1968 Medicines Act. It affirms (Chapter 67 Part 3 paragraph 58) that no person shall administer (otherwise than to himself) any

[24] In addition to Box 10, a number of notable case studies are presented as part of a suite of documents recently produced by the Integrated Care Network, Institute of Public Care and Community Health Partnerships (2010a-d)

such medicinal product unless he is an appropriate practitioner or (our emphasis) a person acting in accordance with the directions of an appropriate practitioner.

Home care workers on the CARMAS scheme can, therefore, help a patient with taking tablets or liquid medicines. They can also apply ointments and creams, assist with the use of inhalers, insert ear drops and (except for post operative prescriptions) instil eye-drops. Specifically excluded are helping with controlled drugs, assisting with nebulisers, catheter and colostomy bags. All the medicines for which assistance is given to users are provided within their original containers (i.e. there are no compliance devices involved). Home carers visit in accordance with the medication regimen agreed. This can involve up to four visits per day. Their work is monitored by the home care managers who liaise, as appropriate, with the pharmacists concerned.

Along with these responsibilities are, of course, requirements that relate to the safe keeping of medicines (in the patient's home); the recording (on a Medicines Administration Record, MAR chart) of medicines taken, refused or left for later self-administration. The safekeeping of medicines is often facilitated through locked (coded) boxes.

The CARMAS scheme now operates city-wide. It embraces near 100 patients and currently involves some 25 pharmacies. A majority of users have some degree of dementia. The appropriate GP practice is also alerted when a user joins the scheme. Other pharmacies (in addition to the 25) are also part of the scheme and, therefore, party to a service level agreement with the Cardiff Local Health Board.

References:

Pike K (2004) 'Medicines Administration in Wales' Pharmaceutical Journal 273, 7310 p152

Royal Pharmaceutical Society of Great Britain (2008) Pharmacy and Integrated Chronic Conditions Management in Wales: A Summary of Published Evidence and Practice Examples

Source: Andrew Evans, Pharmaceutical Adviser (Cardiff Local Health Board)

Diane Sherlock, Home Care Manager (Cardiff Council)

'Hospital admissions have halved since their multi-disciplinary home treatment team] introduction, so I would rate them as successful' (Provider)

As is evident, liaison between services is clearly important if service users are to get seamless provision across boundaries, a key element of which is having an integrated information system.[25] This is particularly important as care workers see service users on a regular basis and are well placed to monitor their health and wellbeing (Hek et al, 2004):

'The care worker came in and said to [wife] you don't look so good today. She opened the curtains and said to me she looks very blue today. She then got on the phone and spoke to the GP who came immediately and phoned an ambulance. If it wasn't for her I wouldn't have noticed her change in colour' (Service user and carer)

[25] Torbay Care Trust have developed such an integrated system ensuring that there is a single point of information for contact for all its services, and that it functions as an organisation in which professionals talk to each other and service users do not need to tell their story twice. For more information see Health Services Journal (2009). The Torbay Care Trust was one of 16 original Integrated Care Pilot sites designated by the Department of Health in April 2009. The two-year pilot programme was instigated to test and evaluate a range of models of integrated care. The programme of integrated care pilots was designed to explore different ways in which health and social care could be provided to help drive improvements in local health and well-being. The aim was to look beyond traditional boundaries (e.g., between primary and secondary care) to explore new, integrated models. Following successes in the original 16 pilots the programme was expanded on 2nd February 2010 to encourage and facilitate the sharing of knowledge amongst a wider range of stakeholders nationally and identify further innovative initiatives. More information can be found at: http://www.dh.gov.uk/en/Healthcare/IntegratedCare/DH_091112.

2.3.3 PROVIDING CARE ACROSS BOUNDARIES – SOLUTIONS

Cross-boundary (generic) support workers

However it has to be noted that some providers, particularly those working with service providers with a learning disability, are already working across boundaries and supplying a wide range of support services through support workers: *'Our support workers have a generic role. We will do domestic tasks, help them around the house. Sometimes we'll go in and them with finances and housing support it all depends on the care plan' (Provider)*

Findings from a pilot study in England (Hek et al, 2004) which attempted to reintegrate health and social care roles under a cross-boundary, or generic, support worker role found that such a service was beneficial for older service users: there was greater continuity of care, it reduced confusion for older people, and provided a seamless service (see also Manthorpe and Martineau, 2008). The '*Rural Health Plan*' (Welsh Assembly Government, 2009d) in particular notes that '*specific emphasis must be given to developing a multi skilled professional and support workforce with generalist skills on the widest practicable basis amongst both health and social care workers*' which is of particular relevance to rural communities.

In this study, commissioners and providers acknowledged that whilst '*there will be challenges to implementing the role there would be benefits to doing so*':

'Makes good sense to have one individual providing care rather than three or four' (Commissioner)

'A generalist workforce with a small number of specialists is the right way forward' (Provider)

'Workforce will need to be more flexible, and move away from specialist care. The trouble with specialist care is that there are flat periods when the specialists can't be utilised' (Commissioner)

'Staff in the future will need to be more highly trained to provide care for service users with more complex needs' (Commissioner)

'If generic working became a reality the current guidelines would become very blurry. For the client they would benefit from a worker that could do almost everything with them, including supporting them in a PA capacity – going out with them and that sort of thing' (Provider)

'For the status of care workers to be enhanced their skill levels need to be improved but the biggest issue here is around funding as a more trained workforce will demand higher salaries – so, in taking this forward political will is important' (Provider)

Generic workers have been much debated and discussed and there are several areas of Wales wherein such services are currently being delivered.[26] There remains much to be worked though regarding the role, including the appropriate regulatory and training/qualifications frameworks needed. The recent health and social care support worker '*End of Project Report*' (Denbighshire Council, 2009) identified both a model for the role and the key elements of a training programme. In evaluating the generic worker pilot in Gwynedd, Bampfield and Burton (2009) were not so prescriptive noting that: '*the success of the education and training strategy should be embedded by developing an ongoing training and support strategy for generic workers*'. In that spirit, research undertaken for this study (reproduced in Appendix 10) has analysed a series of cross-boundary posts, at support worker and other levels, drawing out the implications for Person Specifications, Job Profiles and the underpinning NOS with the aim of adding to the ongoing debate about the place of generic workers in the skills mix for the future of the care at home workforce.

[26] Appendix 9 presents a scoping paper compiled in parallel with this project by the Care Council Project Manager detailing some of the generic worker programmes in Wales.

Making assessments

There is evidence that care workers and front line managers would welcome a review of the assessments undertaken to see what more of a role they might play. Such an enhanced role would be one way to professionally develop the workforce, and as long as workers were deemed to be competent (through formal systems) it could relieve some of the pressures in the system as frustrations with the current arrangements were clear from respondents:

> *'There are lots of occasions where delays in getting Occupational Therapists (OT) assessments can impact very negatively on service users' (Provider)*

> *'The care worker reported to us that a Zimmer frame would be very useful in helping her to get up in the mornings. It was referred to OT and took three weeks for the assessment to be made during which time she fell getting out of bed, was admitted to hospital and eventually unable to return home. Surely some specific types of assessment with appropriate training and competence could be done by supervisors? We know that this would lead to an increase in our workload in part, but the capacity release on OTs would be so significant as to make it worthwhile' (Provider)*

> *'It's difficult to get anything done quickly – three weeks to make visits to assess for commodes is not responsive enough' (Front line care worker)*

> *'We have frustrations with social workers and reviews – isn't there a role for homecare workers being involved in these meetings as we know that service users will often say that they need things that they don't for fear that the service will be withdrawn from them' (Front line care worker)*

Using a '*trusted assessor*' framework (see, for example, Winchcombe and Ballinger, 2005) would be one way to ensure that this development could be achieved. '*Trusted Assessors*', when trained, are able to assess for and prescribe a simple solution or a basic piece of equipment to meet the needs of an individual, looking at activities such as bathing, cooking, toileting, simple transfers to include bed, chair and toilets, simple mobility problems and access including steps, stairs and thresholds. They aim to simplify and speed up the way equipment and adaptations services can be accessed and to promote greater consumer choice, protection and awareness, eradicate waiting lists for assessment and provision related to needs for equipment and minor adaptations, and deliver efficiency gains through the increased use of '*assess and fit*' services. Using frontline care staff and supervisors wherever possible to undertake such assessments would help release pressure on occupational therapists and others, reducing the burden on their workload so that they could focus on more complex assessments, a practice which is currently happening in some areas (see Box 11 below).

Re-ablement services

Local authorities are increasingly developing short-term, specialist home care-based re-ablement services. Re-ablement can be described as an '*approach*' or a '*philosophy*' within care at home services – one which aims to help people '*do things for themselves*', rather than '*having things done for them*'. Home care re-ablement services provide personal care, help with activities of daily living and other practical tasks for a time-limited period, in such a way as to enable users to develop both the confidence and practical skills to carry out these activities themselves.

Home care re-ablement services can take different organisational forms. In some localities, home care re-ablement services are funded and operated jointly with NHS partners. In other local authorities, adult services departments have taken a lead themselves, often as part of the reconfiguration of the authority's home care services. In such circumstances, in-house home care staff receive training in re-ablement approaches and teams are often strengthened by the appointment of occupational therapists (OTs), OT aides and other specialist staff. Home care re-ablement services fall into two broad groups. In '*discharge*' services, re-ablement works predominantly or exclusively with people who have been discharged from hospital. Discharge services can be selective, accepting only people certain to benefit from a re-ablement approach and, as with intermediate care, are likely to be free of charge. In other localities, home care re-ablement acts as an '*intake*' service for a wide range of users who meet local eligibility criteria and are referred for home care services. Often, only people thought unlikely to benefit, such as those with end-stage terminal illness or advanced dementia, will be screened out from an '*intake*' service.

Home care re-ablement services are normally offered for up to six weeks, with some flexibility to continue for longer if the user would benefit from this or if appropriate longer-term support services are not immediately available. Re-assessments and referrals for on-going home care and other services are made at the end of the period of re-ablement. Unlike intermediate care services, which were developed in the context of policy concerns about inappropriate hospital bed use by older people, re-ablement services are usually available to adults of all ages.

There is growing evidence of the effectiveness of re-ablement – there are a plethora of reports accounting for the short-term reduction in care packages and the developmental benefits for staff. A longitudinal study (focusing on the longer-term outcomes for re-ablement) is due to report during 2010. The interim reports (Jones et al, 2009b; and Rabiee et al, 2009) were broadly positive but pointed to the need for further more detailed analysis to be undertaken. In Wales the Social Services Improvement Agency has been working with nine authorities to develop their re-ablement services. As a product of that work a toolkit has been produced and the programme proposes to develop a framework for evaluating re-ablement using Outcomes (Results) Based Accountability methodology.

Box 11

Making assessments at the frontline – care packages and community equipment

Care package assessments

In February, Essex County Council approached one of the agencies providing homecare to undertake assessments for 15 service users who were in need of a review by the social worker. Saving of up to 75% of costs were made and using supervisors already trained to assess service user needs all reviews were completed within 1 week. Two reviews recommended a reduction in the service package, there were three increases, and the remaining 10 stayed the same, although one changed service delivery time.

This new approach is helping Essex to fulfil their obligations to review all service users on an annual basis saves time, cost and improves the effectiveness of the current care plans. Importantly it doesn't replace the responsibility of social services - the provider agency acts as an agent for the authority but all final decisions about care packages remain with the council. As all providers have to assess the service user at the start of any care package and on a frequent basis thereafter they are well placed to send such assessments to their local authority for adoption or input. This can improve the timeliness of assessments whilst saving resource costs for the authority.

Equipment assessments

In Buckinghamshire, two of the most experienced supervisors of an independent provider agency have been trained and qualified by the social services department in the assessment of service users for simple equipment needs. Training took one day and was provided by the occupational therapy team within the authority. Supervisors have been given access to the on-line ordering service of the local authority for all small items (like commodes and walking frames) which are provided free of charge by social services. The process has reduced waiting times for simple assessments, saved costs for the council and enabled better and more responsive care for the service user.

Trusted assessors – Solihull Community Housing

Solihull Community Housing (SCH) is working with the local Care Trust to improve the service to residents who need equipment and/or adaptations for their home. They jointly identified that use of SCH staff to carry out assessments for minor adaptations and equipment could help cut customer waiting times.

The Disabled Living Foundation (DLF) was asked to develop a training programme that was acceptable to the Care Trust and which would ensure that the 'trusted assessors' were competent to carry out this work. The two-day training programme included SCH Safe and Sound staff and some operatives along with the Care Trust's Telecare Co-ordinator and Homecare Rehab officer.

Following the training, the Care Trust's OTs provide a mentoring service; each trusted assessor has to carry out an assessment in presence of an OT and observe an assessment – after both have been completed, they are authorised to order and/or fit necessary equipment. Each assessor also has a workbook that can be used to help them during assessments. SCH also jointly funds two Occupational Therapist posts with the Care Trust. These OT's work directly for SCH and assess customers for the Disabled Persons Register and those disabled people whose homes are undergoing Decent Homes work, or need major adaptations.

Source: **http://www.audit-commission.gov.uk/housing/goodpractice/Stockinvestmentassetmanagement/Pages/trustedassessors.aspx**

Care at Home: challenges, possibilities and implications for the workforce in Wales

2.4 | ROLE OF FAMILIES AND COMMUNITIES

2.4.1 INFORMAL CARE

As noted earlier evidence suggests that families and communities provide more than 95% of the care at home across Wales and without this input there would be fundamental challenges to the formal system of provision. This input is often termed '*informal care*' and is unpaid. In many ways the support provided by carers is the single most important reason as to why people remain at home. Large numbers of respondents in this research study were cared for '*informally*', either in whole or in part, by family and friends:

'My neighbour does my shopping and the garden. He comes in every morning to check on me and see what I need. Then my daughter or son-in-law help with the cleaning I can't do' (Informal service user)

'My family take care of me – they do everything' (Informal service user)

'We've managed on our own with the help of extended family. I don't know what we would have done otherwise but now they are older and it's difficult' (Carers)

'I feel I want to be independent so my daughter does my shopping and the cleaning, if I can see the dial on the microwave I can cook' (Informal service user)

'I'm my father's carer. I do everything for him: I dress him, bathe him, do his meals, cleaning, gardening, decorating – basically I do everything he needs. I wouldn't like to have anyone else do it for him' (Carer)

Box 12

Intermediate care and re-ablement – the Canllaw scheme, Carmarthenshire

The Canllaw scheme (supported by Carmarthenshire County Council, Hywel Dda NHS Trust and Carmarthenshire Local Health Board which have been recently superseded by Hywel Dda Local Health Board) are working in partnership to provide an intermediate care service across the county. The service, developed over eight years:

- provides short term intensive multidisciplinary rehabilitation;
- promotes individuals' independence;
- enables individuals to live in their chosen environment;
- facilitates access to health and social care services as required;
- enables more efficient hospital discharge.

It provides a short (up to 6 weeks) period of intensive rehabilitation. Multidisciplinary teams involved include physiotherapists, occupational therapists, social workers and welfare officers, speech and language therapists, re-ablement nurses, support workers, community psychiatric nurses, dieticians and others provide this rehabilitation. Teams are based in Llanelli, Glanamman, Cwm Gwendraeth, Llandovery, Carmarthen and Newcastle Emlyn.

A service evaluation (2007-08) reported service use by 1,300 people and cost savings through earlier hospital discharge and obviating need for social care packages/hospital admissions. The Council was noted as setting up Assessment and Reablement Teams employing 'Care Assessment and Reablement Assistants' (CARAs) to 'empower individuals to remain independent or to regain independence'.

Source: www.canllaw.com

Care at Home: challenges, possibilities and implications for the workforce in Wales

2.4.2 THE INTERFACE BETWEEN THE FORMAL AND INFORMAL

Whilst there will be certain expectations of the personal care that might be undertaken by relatives, service users very often wish some such tasks to be undertaken by '*others*' (Clark et al, 1998). For the majority of service users who were in receipt of '*formal*' care at home in this study, their care was supplemented by family, friends and the wider community:

'I have a care worker comes in to help me get dressed and do my breakfast. Then I go out visiting, I go to one friend for lunch on a Monday for lunch, I go to luncheon club Tuesday and Thursday. I spend the day with a friend on Wednesday and Friday' (Service user)

'We had help from family. I was paying for personal care, domestic and shopping but they couldn't cook, often meals were part frozen as they tried to cook two meals at once. Family helped out bringing in extra meals, doing extra shopping and cleaning as that wasn't always done properly and they changed the beds' (Service user and carer)

'My friends are very good. I have someone comes in to wash me and do personal medical stuff and then my friends do the rest' (Service user)

'The night sitter didn't turn up and we didn't know no one else had been found to cover so we had to find alternative care. I rang a nurse we are friendly with to see if she could do it' (Carer)

'The care workers don't listen to the family. They seem to feel they've been trained and they know better. If [service user] can't speak up cos he feels intimidated and we complain it seems like we are the problem' (Carer)

There are a range of issues at the interface between the formal and informal workforce, as well as around the boundaries of what care packages offer and what they do not, which arose through the comments of respondents. The number and range of issues identified signal a considerable need for solutions to be identified:

'Lots of the problems we experience relate to misunderstanding about what our role is, how that relates to families and what service users are allowed to ask us to do and what they're not – some people need that little bit more and saying things like 'I know you're upset but all I'm here to do is make your tea' is no good' (Front line care worker)

'It would be very helpful to know the exact circumstances for each person and why they need care before going in – the reason we don't is that clients get added to our list very quickly and without much notice from the council' (Front line care worker)

'Relationships with families can be positive or negative – often it's difficult for them to accept that their loved ones need as much care as they do – but they can be very petty and pointed, criticising you for doing things in the correct way: 'mum doesn't like it when you do it that way' which is obviously very hard, especially when you know that when you make calls when they're not there you get a very different perspective on the family' (Front line care worker)

'One of the biggest problems faced by care workers on a daily basis is not with service users but their families and we as providers are not well supported by social services if we raise issues of conflict' (Front line care worker)

One response to dealing with resolving potential conflicts is to involve carers as far as possible in the training as described in Box 13.

2.4.3 SETTING THE FUTURE AGENDA

The '*Carers*' Strategy for Wales: Action Plan 2007' (Welsh Assembly Government, 2007c) refocused previous Carers' Strategies and reset the strategic direction for the Assembly Government. The document sought to ensure that carers:

- Are not disadvantaged as a consequence of fulfilling their caring responsibilities;
- Are listened to, treated with respect and receive recognition for the important contribution they make in supporting people to sustain their independence;
- Are able to maintain as normal a life as possible outside of their caring role;
- Have timely access to an assessment of their own needs;
- Have access to services that will enable them to be properly supported;
- Are able to access employment, education and leisure opportunities.

The key priority areas for action – health and social care, information, support, young carers, carers and employment – identified in the 2000 version of the Strategy were sustained as being of continued and enduring importance. The future direction in Wales will also be shaped by the Carers Legislative Competence Order and its respective measures. This will be instrumental in setting the agenda for dealing with issues at the interface between the provision of formal and informal care. There are seven important aspects to be considered:

1. There will be a new duty on the NHS to work with partners to develop local information strategies that will ensure carers get appropriate information and advice;
2. There will be a new duty on the NHS and their partners to actively engage with and involve carers when making decisions about the provision of services to or for carers or the person cared for;
3. This duty to consult will apply to the overall planning, commissioning and delivery of local services that affect carers or the people they look after;
4. This duty will also apply to individual care plans which is a very significant change;

Box 13

Carer involvement in care worker training – Wrexham

Wrexham County Borough Council is developing frameworks in which carers can have a meaningful input into social care policy and practice frameworks. The initiative helps the Council to fulfil its statutory obligations under the 2004 Carers (Equal Opportunities) Act and to deliver in relation to the policy frameworks set out in their 'Participation and Involvement Strategy' and 'Health, Social Care and Well-being Strategy'. It responds to concerns that services have sometimes been insufficiently sensitive to changing user needs and have taken insufficient account of the expertise, views and support needs of carers. It also helps in relation to the Council's commitment to improve the qualifications of the social care workforce (embracing statutory, voluntary and private sectors).

Users of social services in Wrexham were already in receipt of a Newsletter from the North East Wales Carers Information Service. Some 400 carers were registered with this service. The Newsletter was used to identify carers who would be interested in becoming involved in staff training. This was considered as important to add 'authenticity' to their voices and helping to ensure that the training provided to staff was focused, relevant and clear. Carers to support staff training were also sought through Glyndŵr University (formerly North East Wales Institute), which facilitates service users and carers to become involved in student social worker recruitment and training. An initial meeting of carers who responded to the Newsletter item found very positive support for such an initiative but it also indicated issues about service frameworks that could feed into the Council's planning processes and delivery frameworks. As a consequence the Council's Commissioning and Planning Officer with responsibility for carers' issues was invited to join what became the Carers' Staff Training Group and has now been merged into the wider Carers' Forum. Staff training is now fixed item on the agenda for that Forum. The Forum contributes to the Borough's Health Social Care and Well-being Strategy and is, therefore, formally constituted.

The broader issues of concern for carers were identified as

- assessment of needs and the need to facilitate 'breaks' for carers;
- the need for information and advice in relation to rights and services;
- a range of shortcomings in home care services; and
- the skills needs and training of social care staff.

This case study is primarily concerned with the last of these. And it is of crucial importance to note that a key concern of carers relates to the attitudes of some staff both to service users and carers. In some cases this appeared to be accompanied by poor communication and even literacy skills. This fact alone was, in the view of carers, was alone sufficient to justify their involvement in training. The broader context, however, is one in which carers are, by virtue of bringing direct knowledge of a wider range of issues, beginning to play a more significant part not just in training but through ensuring that some important right questions about the role of carers are asked as a prelude to changing policy and practice frameworks.

It must be noted that, at present, the carers involved in the Wrexham staff training initiative are relatively few. Around 10 carers are engaged in the Carers' Forum. One member is also involved in 'Outside In', a programme by which service users and carers support teaching and course management for social work and other degree programmes at Glyndŵr University. Expenses are paid. There is no claim that the Carers' Forum is representative. It is, however, clear that Forum members offer views and concerns that are held in common (despite their caring roles relating to very different circumstances) and largely resonate with those of other carers. The users that they care for range from a younger person with cerebral palsy to spouses and parents with Parkinson's Disease or dementia. Representativeness would, in any case, be an inappropriate goal given the very nature of caring - the consequences of which present substantial hurdles to participation.

Those within the former Carers' Staff Training Group met in March 2009 with groups of staff – from the Council, the voluntary and the private sectors. The intention of the meetings was assist staff understanding of carers' perspectives. Feedback from the sessions revealed that the staff who participated gained a great deal. The benefits were particularly apparent for direct staff (providing hands-on support in people homes or in residential or respite care). In relation to the legal rights of carers, the pressures faced on a day to day basis by carers, the options for providing support to carers and the importance of partnership working (involving care provider, user and carer). The feedback from these sessions was seen as encouraging and has helped to give impetus to the Carers' Forum as its involvement in training is developed. Relating to this a Q&A session with managers and a 'promotional' DVD are planned. The DVD, for regular use in training, will highlight the circumstances and experiences of carers and the opportunities that carers afford – not just in caring but, with appropriate support, in playing active parts in wider family and community life.

Source: Kate Meredith, Staff Development and Training Officer (Wrexham County Borough Council); Members of the Carers' Forum.

5. The partnerships will not only be with social services in the local authority but should include other areas such as housing, education, leisure etc. Other partners should include the voluntary and private sectors;
6. The provisions of the Measure encompass carers of all ages, including young people under 18 who are caring;
7. The Assembly Government will have the power, through regulations to define the content and scope of the strategies and define an NHS organisation as the lead authority.

Building on this, and whilst ostensibly focused on England, the Standing Commission on Carers (2009) was created with the key aim of contributing to the development and delivery of the national Carers Strategy. Their recent report outlined recommendations for the next phase of its work reflecting its commitment to ensuring that the 10-year strategy achieves its goals by 2018. The main recommendations for the next phase of the Commission are set out below and are useful in helping to see how the agenda may develop:

1. Following the publication of the Green Paper, Shaping the Future of Care Together, the Commission will wish to contribute to the debate from the carers' perspective and within the wider context of the transformation of social care and NHS reforms, to ensure that mechanisms for future funding arrangements fully reflect and respond to the critical role of carers within the health and social care system;
2. The Commission should seek further discussions with DWP on welfare reform and press for a timetable for reform to be established;
3. It is vital that PCTs are encouraged to recognise the importance and value of supporting carers. The Commission should work with both the Department of Health and the NHS to gather evidence of how the new resources in PCT baseline allocations have been spent and on the cost-benefits and improved health outcomes of supporting carers in their caring roles, including the provision of breaks;

4. The Commission should consider holding early discussions with the Department of Health, the Local Government Association and Association of Directors of Adult Social Services on the impact of the transformation agenda on the viability of third sector organisations, given the important role they play in developing, designing and delivering innovative services and support for carers at local and national level;
5. The Commission should keep a watching brief on, and contribute to, the Department for Children, Schools and the Family's work on improving outcomes for young carers through the development of methods to help to identify and assess young carers at an early stage;
6. In the light of widespread concern about the implications of demographic change (and a recognition that the majority of carers are supporting older people) the Commission should actively consider the range of issues relating to quality of life and care and support for older people as identified in the Ageing Strategy Building a society for all ages and in the forthcoming Green Paper on Families and Relationships. In its discussions, it should also keep in view the role of lifetime carers and '*sandwich generation*' carers;
7. Carers should be fully included within all forthcoming equalities legislation and thereby protected from discrimination. The proposed protection of carers from discrimination in access to goods, services and employment within the forthcoming equalities legislation has been widely welcomed. The Commission should maintain a close watch on the progress of the Equality Bill and contribute to discussions around carers' issues within the emerging equalities agenda;
8. The Commission should scrutinise how the Government includes carers in its consultation on the scope, impact and effectiveness of the NHS Constitution.
9. The Commission should maintain a close watch on the implementation of the Carers Strategy to ensure that carers of both younger and older disabled people receive appropriate information, advice and support around hospital discharge and that community services are age-appropriate and reflect personal preferences and lifestyles;
10. Recognising the importance of co-production, the Commission should develop a range of working groups and thematic meetings in order to bring key stakeholders together to explore key policy issues in depth and inform the Commission's wider work.

2.5 | OUTCOME-FOCUSED WORKING

2.5.1 DEFINITIONS AND APPROACH

Glendinning et al (2008) have argued that '*[home care services are] often acknowledged to be inflexible and insufficiently responsive to users' desired outcomes…implementing outcomes-focused services requires a whole system vision and strategy*'. In this context '*outcomes*' refer to the impacts or end results of services on a person's life and outcomes-focused (OF) services are therefore those that aim to achieve the goals, aspirations or priorities of individual service users. They can be contrasted with services whose content and/or form of delivery are standardised, regardless of the circumstances of users; and with services whose goals, content and mode of delivery are primarily determined by those who commission or deliver them rather than those who use them (Glendinning et al, 2006).

There is a high degree of consistency between different studies in the outcomes that are valued by older people; these relate closely to factors that older people have identified as contributing to quality of life. The OF approach should be relationship-centred, acknowledging family, community, and others things that impact on this quality of life. The '*Senses Framework*' (Nolan et al, 2006) offers a useful way to consider such outcomes. There are six senses that can be used in making decisions about service users' needs or in undertaking OF assessments or reviews – the senses of security, belonging, continuity, purpose, achievement, and significance.

Local Area Co-ordination (LAC) can also provide a useful context for the exploration of outcomes and enable services delivered in this way to be as effective as possible. LAC is a community facilitation role, originally developed in Western Australia for supporting people with disabilities, to live good lives in their communities. It places emphasis on helping people to draw support from their communities and it does this by working to increase both the capacity of individuals and the capacity of communities. It is a way of empowering people directly by increasing their assets so that they can live lives as '*active citizens*' with support in their community.

Box 14

Vela Microboards in Northern Ireland

What is a Microboard?

A Vela Microboard is formed when a small group (micro) of committed family and friends join together with a person with challenges to create a non-profit society (board). Together this small group of people address the person's planning and support needs in an empowering and customized fashion. A Vela Microboard comes out of the person centred planning philosophy and is therefore created for the sole support of one individual.

Essential Components of a Microboard

- The process must be focused on the dreams and wishes of the person for whom the board is being created;
- All Microboard members must be in a close, voluntary, and committed relationship with the person for whom the board is being created;
- These close relationships are the foundation of the board and must be honoured above all other activities.

Who can sit on a Microboard?

Family, friends, and acquaintances who are committed to knowing the person and to having a reciprocal relationship with them. Relationships are the most important component of a Vela Microboard. It is not necessary that Microboard members have expertise in a specific area of disability or support services. The important gifts that Microboard members bring to their society is their relationship, knowledge of, and commitment to the person. The service skills can be learned or purchased from others.

In British Columbia, to satisfy legal requirements of the provincial Societies Act a minimum of five people are required to incorporate the Microboard. The person for whom the board is established may sit on their own Microboard and can be counted as one of the five members. Too many people on a Microboard can lead to it becoming bureaucratic and become too difficult to manage. As a rule, five to seven people keep it dynamic and personal. However, the number of members is ultimately a decision that should be made by the individual and their personal network. Someone who is paid directly by the Microboard can not sit on that board, it is considered a conflict of interest.

What do Microboard Members do?

Spend time with the person, be a friend, in whatever way is natural for the people involved. Board members are a critical part of helping to plan with the person, create supports, and possibly deliver services. If the Microboard decides to provide direct services they hire staff, and become employers. In British Columbia, at the Microboard's request, Vela facilitators walk the Microboard members through the process of planning, developing, and maintaining services.

In British Columbia, to maintain legal society status, there are also 'official' positions that will need to be filled on the Microboard. The President decides the agenda, organizes meetings, and chairs meetings. The Vice-President carries out the duties of the president during her/his absence. The Secretary conducts the correspondence of the society, records the minutes and keeps all records and documents on behalf of the Microboard. The Treasurer keeps the financial records for the Microboard. The positions of Secretary and Treasurer can be combined to create one position of Secretary-Treasurer. If the Microboard hires their own staff directly, they may wish to create a board position of Staff Liaison. This position would act as the communicator between the staff and the Microboard.

Vela Microboards also have meetings to maintain their focus and supports. The frequency of meetings and formality is up to the individual Microboards. Many Vela Microboards meet monthly during their process of development. Once they have been up and running for a while, some Microboards choose to meet less frequently. One of the most important functions performed by Vela Microboard members is ensuring there is a balance between activities where the focus

person is getting something and giving something. This ensures that the person experiences broadened horizons and has the opportunity to share their gifts and talents. The role of the Vela Microboard is not to shower the person with a steady stream of social opportunities. Rather, the Microboard's purpose is to ensure that the individual becomes a part of the fabric of community, thus safeguarding that person's future.

Principles Microboards Follow

1. Microboard members must have a personal relationship with the person for whom the board is created;
2. All people are assumed to have the capacity for self-determination and this capacity will be acknowledged and respected and demonstrated in all the dealings of the Microboard;
3. All decisions made by a Microboard will demonstrate regard for the person's safety, comfort, and dignity;
4. The more complex a person's needs are, the more important it is that the services are customized and individualized to support those needs;
5. All Microboard members will conduct their board business in the spirit of mutual respect, cooperation, and collaboration;
6. All services developed and/or contracted are based on the person's needs, not availability of services;
7. Microboards will only negotiate contracts with people and/or agencies able to demonstrate a concrete ability to provide services as identified by the Microboard. These services will be person centred and customized to meet the individual's needs;
8. The staff that work for or with the person through their Microboard, are not "attached" to the buildings in which the person lives, works, volunteers, or recreates. They work for the person, not an agency or business.

Functions of Microboard Members

The first role is to get to know the person and establish a personal, reciprocal relationship (friendship) with them. They then act as sponsors to the community ensuring the person participates in community activities with Microboard members (i.e. family functions, social events, etc.) This is done in ways that are natural for each of the people involved, not as prescribed through written expectations. Also they ensure the person has the opportunity to both receive and give from and to their community as well as with other individuals in their networks. Once the functions have developed, the following processes occur:

1. Complete a person centred planning process that will be used as part of the development of a proposal for supports;
2. Incorporate as a non-profit society;
3. Identify and request funds for services;
4. Identify and negotiate services;
5. Maintain and/or monitor services;
6. To honour legal requirements of the British Columbia Societies Act, a minimum of five board members must sit on the Microboard;
7. To respect the intimacy of the Microboard process, no more than seven or eight members are recommended for any board.

Vela Microboards Northern Ireland

Vela Microboards as an organisation was first introduced to Northern Ireland in 1997, when a group of dedicated people came together and secured funding for a two year project to advance the concept of individualised support. Following the success of the initial project Vela Microboards secured funding to formally establish the organisation.

In 2005 Vela Microboards having registered as a company limited by guarantee and attained charitable status undertook to advance the work of the initial pilot. As a regional voluntary organisation managed by a board of directors on a voluntary basis and together with any staff employed Vela Microboards NI provide direct assistance to people who are interested in setting up an individual Vela Microboard. The board also provides ongoing support to individual Microboards throughout Northern Ireland. Vela Microboards NI is committed to addressing the following:

1. Social exclusion of marginalised people;
2. Uptake of Direct Payments;
3. Promotion of the Microboard concept;
4. Innovate and creative models of empowerment;
5. A community development approach to meeting individual need;
6. Capacity building for families, carers, and community.

Source: http://www.microboard.org and http://www.velamicroboardsni.org.uk

2.5.2 OUTCOME-FOCUSED WORK IN PRACTICE

There are an increasing number of examples of outcomes-focused working in Wales, one of which is covered in detail in Box 16 below. Another of these, the '*All Together Now*' project based in Swansea, is a pilot study providing and promoting outcome-focused care with a group of selected participants. In a recent journal article discussing the project findings to date the authors stated that '*the need for more holistic and inclusive approaches to assessment and care management for older people is widely promoted but difficult to achieve*' (Andrews, Driffield and Poole, 2009). This was echoed by commissioners and providers in this study. Some also expressed a view that whilst OF service provision is considered to be beneficial to all stakeholders this isn't always the experience in practice:

> *'It's important for everyone to have their say. What do service users want to see? What are they asking for in terms of level of service, that's the fundamental question. And then from there, what is it that providers are currently providing, and what do we need to see that's different in order to provide a more effective and efficient and valuable service? So each person or each agency has their own input and then from there we need to look at how responsibility is apportioned and who does what to achieve the overall result' (Commissioner)*

> *'Professionals are not listening to what service users want…organisations are saying "these are the professionals we've got so this is the service we can offer", rather than the other way round, and saying "what are the needs of the local population and how do we meet them"?' (Provider)*

> *'It's pointless investing lots of public money in having ideas about what it is that people want if we haven't consulted the people receiving the service to find out what they do actually require, and are they actually receiving that at this time […] Some very valuable contributions could come from service users who can see where the improvements might work for them. And we might be able to achieve a great deal more by doing that, and we'd have a great deal more value for money in terms of the investment in the planning and the strategy process by listening to service users and how they feel that the future needs to go for them' (Commissioner)*

> *'There will always be the limit of a budget constraint to work within, therefore that will to some extent shape and constrain the structure and the way in which we deliver the services' (Commissioner)*

2.5.3 IMPLICATIONS OF THE MOVE TO OUTCOMES

As is evident from the narrative that follows a number of themes arose when engaging service users and carers on the topic of outcomes. Those that related to service provision in particular were around reliability, flexibility, continuity of care, maintaining independence, and care worker skills. Many of these were raised in relation to Section 2.2 on Independence and Choice. What is significant is that there are a series of implications for workers from what follows.

Continuity

One of the drivers behind the move to OF working is to ensure a more joined up and focused service for individuals. It is clear that general comments about continuity of care (albeit not from service users explicitly receiving OF services) demonstrate that there is some way to go before this will be resolved:

> *'It was different people turning up all the time. It's not so bad if they are taking her out, but when they are washing somebody you want the same person' (Carer)*

> *'We had a care worker each in the morning to wash and dress us both, then another came to give us breakfast. We had a different carer at lunchtime and again at teatime. Another carer came to do the cleaning and another came to do the shopping and then another one to get us ready for bed. Each would only do what was in their list of tasks you couldn't get the one who did the cleaning to make a cup of tea or if they came to put us to bed they wouldn't take the dishes away from tea' (Service user)*

> *'It's often a different person every time' (Service user)*

These findings support a Dutch study which reported that service users were dissatisfied with the continuity of care because too many care workers were involved and that they '*attached a great deal of value to a small team of carers*' (Bosman et al, 2008). Linked to this were a series of challenges that arose in relation to the lack of communication between care workers:

'There was no continuity. We had eight or nine different people coming in and it was tiring telling them the same thing. They need a system where they hand over information between carers to save you having to do because you do forget things' (Service user)

'You have to keep telling each new carer them the same thing. He [service user] has a long history – why do we have to keep going over it? The care workers need to have more information on the client's condition' (Carer)

Flexibility

It is apparent that a flexible service which would be '*allowed*' to provide lower-level support needs is required by many people. Percival and Hanson (2005) noted that what is often required is low-level support which enables service users to function at a level commensurate with their peers. Although their work focused on the support needs of service users with a visual impairment, it is evident from the views of service users expressed in this study that the need for such flexible support is not restricted to individuals with sensory impairments but is a requirement across all client groups. Indeed low-level preventative social care has been shown to improve quality of life and maintain independence (Help the Aged, 2004).

Box 15

Outcome Focussed working in Wales – strategic and operational

a. Strategic – Torfaen CBC outcome-based commissioning pilot

In Torfaen, in April 2007 there were no Commissioning Strategies, the service direction was not clearly mapped out and performance was measured more on activity than results. By February 2009, there are nine joint Health, Social Care and Wellbeing Commissioning Strategies, action plans are now outcome focussed, there are joint Strategic Implementation groups in place and performance is measured by progress on strategic outcomes.

In order to understand what needed to change, a review was required of commissioning practice. In part the review looked at the kind of knowledge upon which local authorities had always made commissioning decisions, and concluded that it had been focused on two key questions: how much are we doing, and how well are we doing it? Moving towards an outcome based commissioning (OBC) system (developed in the US and practised in different parts of the UK notably in Worcestershire and Thurrock) foreground a completely different approach. OBC is not undertaken on the basis of quantity, or the quality of that activity, but instead by asking a different commissioning question: is anyone better off as a consequence of the activity? The diagram below provides a representation of these approaches, and reflects on what OBC practice needs to reflect. Commissioners in Torfaen recognised that hitherto their approach fell into the top half of the diagram, which whilst giving them greatest control over the commissioning process, meant that the locus of their power centred on the things that made least impact on the ground in improving quality of experience and well-being for users.

Making the transition towards Outcome Based Commissioning (OBC)

In Torfaen OBC is all about shifting the focus from activities to results, from how a programme operates to the good it achieves. Recognising that joint commissioning strategies (which locally set the direction for health, social care and wellbeing commissioning over a five year period) had benefits for users/carers, staff, providers and commissioners, was an important first step. From the commissioners point of view it helped in breaking down professional and organisational barriers, to undertake effective gap analysis and service planning, to use resources across all sectors – statutory, independent and voluntary – more effectively, and to manage demand from demographic and technological changes efficiently. Building on this, their approach to developing outcome-based action plans was predicated on evidence. Attending Institute of Public Care workshops, and learning from best practice across UK led to a corporate and whole council approach to OBC, especially in respect of older people. After consultation with stakeholders on which outcomes should be the most important, all corporate and strategic plans have now been unified under the same single aim: that all older people in Torfaen are happily independent.

So what might this OBC look like in practice? If, for example, you were commissioning a service focused on the mental health outcomes of older people you might look to commission services that had a positive change in wellbeing, and helped to maintain these benefits, measured in part by the feelings and attitude of service users. You would also look to commission services which ensured that users felt valued. Or, for example, you might look to commission services that had older people living happily independent lives as an outcome. In this instance you would look to commission services that promoted positive changes which, for example, improved mobility and confidence through a care package of that allowed people choice and voice.

How might an OBC care plan be developed and reviewed?

The following list of criteria gives an indication of the kind of data collection requirements that an OBC system might have. These describe personal outcomes to be achieved and are open to additions by clients. Importantly they scope the range of potential outcomes in such a system (each is prefixed by 'you will'):

- Feel safe;
- Live where you want to, in an environment comfortable to you;
- Have control over your daily life and routines;
- Have things to do. See other people;
- Stay as well as you can;
- Improve your skills and confidence;
- Have improved mobility and be able to get around your home and community;
- Have reduced symptoms/improved health;
- Maximise your income;
- Be listened to;
- Feel valued and respected;
- Have support that is flexible and gives you choice;
- Have support that is reliable and timely;
- Have support that is responsive to changing needs.

In being established, care plans need to identify personal outcomes along the lines of those listed above. Reviewing the care plan after data collection has taken place is essentially a function of answering two questions: 1. Do the current mix of services you receive meet the outcomes you set?; and 2. Are the outcomes that were set still the same outcomes that you want to achieve?

Meeting the challenge of OBC

In no small part moving to an OBC system requires significant change in culture. In Torfaen significant steps have been taken in this direction, including, for example, having joint and shared executive board posts between the statutory health and social care organisations. There must pervade locally an attitude that outcomes-focused performance management becomes the responsibility of all, which in turn requires leadership at all levels, and across all partners. In part this has been achieved in Torfaen, through the creation of executive posts which have a seat on the boards of the Local Health Board (commissioner of health services) and the local authority (commissioner of social care services). To work effectively however, it needs a 360? approach to ensure implementation – all partners and stakeholders need to be involved and committed at all stages. Putting aside cultural and political dimensions, one of the most significant technocratic challenges centres on determining an agreed dataset and collection mechanisms.

In terms of what comes next, OBC specifications for domiciliary care contracts are currently in draft in Torfaen, prior to consultation. In many ways, writing an outcome-based specification is the easy part. The difficulty will come in care planning and service delivery planning, in service delivery itself, and in performance management and review.

b. Operational – Newport City Council operational outcomes-focused pilot

In 2007, CSSIW held an event at which an idea emerged – that to undertake an operational pilot of outcomes-focused (OF) care at home in Wales would be an interesting departure. At that event, Newport was proposed as the pilot site for Wales, and to date whilst much OF developmental work has been undertaken across Wales, all of it (apart from that in Newport) has been strategic rather than operational.

Context

In the UK, work on outcome focused approaches has been taking place at two levels, at an individual level and at a strategic level. At an individual level, Newport utilised the framework initially researched and developed by the Social Policy Research Unit at York University (Nicholas et al 2003). The pilot has therefore defined three types of outcomes: maintenance; change; and process outcomes. At a strategic level Newport have examined the 'Outcome/Results Based Accountability' model developed by Mark Friedman.

Newport Council's own home care staff currently provide one-third of the hours of support across the patch, but have 40% of users on the basis that the local authority are the only provider that undertakes lower level support in 15-minute calls. In the existing system of assessments in Newport, social workers are at the heart of the process, approaching clients to determine care plans. Six week reviews are undertaken, some of which are done jointly with service users, and this is followed up by an annual review.

The essential element of the project was to deliver support more flexibly from a market that was regarded as a 'traditional' and 'rigid' care provision across the community. The contracts we have in place for domiciliary support are spot based contracts with minimum time blocks. It was recognised that the Contracting arrangements for the domiciliary care market needed to be adjusted and we were able to inform an approved provider process which will lead to a re tendering of the market in 2010.

Care at Home: challenges, possibilities and implications for the workforce in Wales

The pilot OF approach

The OF pilot has put the citizen firmly in control of the process. T The pilot project currently provides 345 hrs to 61 clients. In total we have provided 441.25 hrs to 82 clients throughout the pilot to date. This new approach has several features:

- Duty and assessment teams undertake their work with outcomes firmly in mind

The process will be undertaken with new clients, but the eligibility criteria for services will not change. New assessment documentation have been developed which emphasise the outcomes as defined by those clients. Bringing together assessors and providers has also unified the approach – providers are now much more involved in review processes with social work staff;

- OF Support Plans replace Care Plans

Assessment process and interviews are now explicitly linked to an OF Support Plan, which codifies the change in emphasis from care to support. The support plans are less rigid than care plans, and thus the care is more flexible – for example, service users are able to manage hours by 'banking hours' up to the agreed package;

- Supported decision-making tool backs up the move to outcomes

In order to ensure there is a structure around the move to OF, there has been developed a decision-making tool which reinforces the approach.

Challenges and next steps

Moving to such a way of working requires a significant change of attitude and culture. Unsurprisingly this has proved challenging, and the Council are very open to learning lessons at all stages of this process. There is a perceived need to strengthen the review process such that service users truly are at the centre and in control of the process. In addition, four workstreams were identified so that the transition from pilot to full marketplace (scheduled for October 2009 when the pilot comes to an end) can be made as seamlessly as possible: finance and market; training and strategy; competency training for providers; and assessment tools and care management

Sources:

Torfaen OBC | Alex Crawford, Commissioning Officer (Torfaen County Borough Council)

Newport Operational Pilot | Jonathan Griffiths, Manager (jonathan.griffiths@newport.gov.uk) or Lisa Broomsgrove, Project Officer (lisa.broomsgrove@newport.gov.uk) – see http://www.newport.gov.uk/_dc/index.cfm?fuseaction=socialcare.homepage&contentid=cont356787

As noted previously in relation to the barriers to independence, flexibility of care was a theme highlighted by service users and carers in relation to OF working. This was recognised by the '*Rural Health Plan*' (Welsh Assembly Government, 2009d). The Plan reports that developing integrated social support interventions, both formal and informal, helps people to stay in their own homes for longer which is especially important for ageing rural populations. This support can take a variety of forms including informal volunteer support and networks to schemes such as '*Care and Repair*' as well as statutory services such as those providing aids and adaptations. Echoing the comments above, in addition to care that addressed basic issues, a number of service users in this study stated that they would like a flexible service that addressed their wider needs. This included help with gardening, putting shopping away and reading mail, which an OF service could deliver:

'I want to be independent so I don't want full time care but I would like some help around the house and with shopping. I would like some help with the garden as my oxygen won't go out there. Also shopping and some cleaning – I'm restricted because my oxygen pipe will only reach so far – it's a real barrier for me' (Service user)

'Care plans are too rigid – you have to justify your need. Individuals have other needs outside of personal, social and domestic. You can't get someone to write a letter. If you have an hour for a bath, and that doesn't take an hour why can't they write a letter for you?' (Service user)

'Care packages need to reflect the individual – people may have the same condition but there are underlying factors that change those needs' (Carer)

Care at Home: challenges, possibilities and implications for the workforce in Wales

Box 16

Providing community services – not care but support

a. 'Village Agents' in Gloucestershire

Gloucestershire Village Agents bridge the gap between the local community and statutory and voluntary organisations able to offer help or support. They provide high quality information, promote access to wide range of services, carry out series of practical checks and identify unmet need within their community. Through training and access to appropriate information resources, the Village Agents provide a service within their communities both in the short and longer term. Village Agents are recruited locally and trained to provide face to face information and support which enables individuals to make informed choices about their future needs. The service is provided primarily to older people, but other disadvantaged and isolated people are also be able to receive Village Agent support. Village Agents Offer a facilitated signposting service and put people in direct contact with the agency or agencies, whether statutory or voluntary, that is able to provide the services they need. The scheme is managed by Gloucestershire Rural Community Council and is funded by Gloucestershire County Council and Gloucestershire Primary Care Trust. Village Agents began in 2006 as a pilot project funded by LinkAge Plus in conjunction with the Department for Work and Pensions.

Source: **https://www.villageagents.org.uk**

b. The Food Train

The Food Train is a grocery shopping, befriending and household support service for older people in Dumfries and Galloway. Food Train began in 1995 following a community survey of older people that found many of them struggling with their weekly grocery shopping; an idea was developed to ease this burden on older people. A partnership of local shops and volunteers formed and Food Train was born, becoming a limited Company in 1995. Charitable status was awarded in 1996 followed by Domiciliary Care approval by the Local Council in 1997. From its early days of a few deliveries every week to a handful of customers, Food Train is now a thriving multi award winning charity with six local bases providing support services to older people promoting independent living.

Food Train's aim is to support older people to live independently at home. Their preventative services address the difficulty older people face getting their weekly grocery shopping, doing jobs around the house and the growing isolation that comes with failing health. Food Train also aims to provide a wide range of supported volunteering opportunities for people of all age and ability. Food Train is a 'one stop shop' for older people - by providing services or helping them access services to help them live independently at home for as long as they wish and are able.

Shopping Service

The shopping delivery service is a simple process; customers complete a blank shopping list which is collected by volunteers – on collection of the completed list a blank one is left with the customer for the next time. Help can be provided for any customer unable to write their own shopping list. All the completed orders are handed in to the local shops that make up the orders fresh for delivery by our volunteers on a nominated day. The shopping is delivered in a box which is unpacked by the volunteers who will help put things away if needed. The customer pays for the shopping plus a small delivery charge. To access the service customers must be unable or have difficulty getting their grocery shopping. Customers can self refer or be referred by anyone, there are no forms to fill in and the service can begin immediately. Customers use the service weekly, fortnightly, monthly and short term or long term to suit their own needs. Each person pays £1 per year membership to use Food Train services.

EXTRA Service

Customers using the shopping support service can also now access Food Train 'EXTRA'. The initial visit comprises of a home safety check with referral to Fire and Rescue and Handyvan services locally, if needs are identified, followed by a general check of what help is needed around the house. Customers then receive a regular monthly visit for 1-2 hours; volunteers will help around the house e.g. inside window cleaning, defrosting the freezer, changing light bulbs, cleaning cupboards while having the necessary 'cuppa and a blether'. No jobs are undertaken that require a qualified tradesman, and there is a small charge for jobs.

Source: **www.thefoodtrain.co.uk**

Maintaining independence

As in Section 2.2, there are some service users who perceive the sense of '*being cared for*' as a loss of control (Glendinning et al, 2006). Sodeen et al (2007) argued that '*it's important that service providers recognise and support service users in maintaining their independence as it provides an important contribution to wellbeing*'. What is apparent from the comments made by service users in this study is that they want services that support them in maintaining their independence. A key element of this is having control over tasks that are being done and being involved in saying how and when things get done – i.e. moving to an OF way of working:

> *'They do what tasks they want, my wife tells them what she wants done but they don't always do. They just don't listen to her' (Service user)*

> *'They should come in and ask what do you need today, instead they come in with a list of tasks that are on the care plan and may not need to be done' (Service user)*

> *'They treat us like babies and we're adults. They do what they want, not what we want' (Service user)*

> *'At least with the direct payments she has more control. She can determine the range of tasks that are required and she will be able to go out and do things without having us take her. She will have some independence from us' (Carer)*

These findings are consistent with those of Meyer et al (2007) who noted that service users want their personal autonomy facilitated by care workers and that this can be achieved when the care worker follows the preferences and outcomes of the service users with regards to how tasks are completed: '*they need to learn how to take direction – I know what I need and how I like things done*' (Service user).

Skills

A number of service users and carers felt that care workers needed more training in specific areas to enable them to adequately support service users, especially when working under an OF framework. Common training issues related to communication and handling skills. Disability awareness training was an issue raised by some service users and carers – others felt that client specific training was necessary so that care workers have the right knowledge about the person they're caring for:

> *'Care workers need to spend time with the family and the client and the family needs to be involved because sometimes things only come up during the care interaction, you can't predict them. That's when they need family input' (Carer)*

This particular perspective again echoes the findings of Meyer et al (2007) who noted that some service users had stated a preference to train care workers themselves in order to get care that was appropriate for them. It also reflects the views of some service users and carers who felt that training for service users themselves would enable them to address issues within their care and facilitate them in requesting and directing care workers: '*[I've been] constantly asking for lifting and handling help for 21 years – [and it is] not forthcoming*' (Carer); '*How to use the hoist, lifting and handling*' (Service user).

2.5.4 SUMMARY – THE CHALLENGE OF OUTCOMES

Across the UK different stakeholders are struggling to come to terms with the processes required to deliver outcomes. Producing '*outcome-based*' care plans is one such example, and whilst there are a number of templates available to base an OF review around (see for example Bennett, Cattermole and Sanderson, 2009), there is a real danger of a plethora of different versions being produced unnecessarily.

Outcomes for service users will vary greatly. Outcomes for the workforce delivering that care will also vary greatly. There will still be tasks required to deliver people's outcomes. Understanding the implications for the workforce (in training, cultural change, and relationship between task and outcome) in making the transition between task and outcome is therefore fundamental here.

Care at Home: challenges, possibilities and implications for the workforce in Wales

SECTION 3 | Implications for the future – conclusions and recommendations

3.1 | FUTURE PROOFING

This report focuses on how best to equip the care at home workforce for the challenges of the future. Many of those challenges are already with us, and a credible strategy needs to address them. But the future will also create new challenges, and may cast existing ones in a different light. Our recommendations therefore need to be '*future proofed*'.

Many of these changing contextual factors are addressed throughout the report where they are encountered, but one major potential future change should be singled out for specific attention again here – the likely changes to the ways in which social care is funded. As noted earlier the '*Paying for Care*' consultation outlined five options, and assessed their capacity to meet the core principles of social care provision: universality; affordability, sustainability and fairness; clarity; and assistance in providing independence. There is inevitably much uncertainty about which of these options will be adopted but as far as the care at home workforce is concerned, each will have the same broad consequences, albeit delivered via different mechanisms, since each is designed to meet the same core principles set out above. Where they will differ is in the extent of their impact across the criteria below taken from the document:

- More workers, as more money is introduced into the system, and the emphasis shifts from institutional care;
- More clients, as the population demographics change and more people live longer at home;
- Greater equity of provision, albeit with different sources of funding;
- More control vested in the client, as each option seeks to provide a more '*personal*' service; coupled with
- Greater clarity for clients about how to get what they need.

The key variable, as far as the care at home workforce is concerned, is the extent to which each option requires the client to negotiate and manage their own provision. Each of the recommendations which follows, therefore, is relevant to each of the proposed funding options.

In addition the research team sought to canvass a cross section of opinion about the issues and possible solutions identified during the course of the study. Ahead of the production of this report, the '*Your View*' document[27] (which contained all of the salient information on issues and solutions) was sent to the 240 service users, carers, care workers, managers, commissioners and expert stakeholders who had participated in, or contributed to, the study. They were offered the opportunity to review the information that had been gathered and provide comment. The exercise ran for a four-week period between 22nd February and 19th March 2010. The comments made have been taken into account in the recommendations that follow.

3.2 | RECOMMENDATIONS

We make five Key Recommendations for consideration, and these are underpinned by 22 specific '*sub-recommendations*'.[28] As far as possible we have indicated the relevant organisations and partners that would need to be involved to make each of these a reality.

Our Key Recommendations are as follows:

1. **Recognise the value of the care at home workforce;**
2. **Enhance the role of the workforce in assessing needs, planning, coordination, reviews and working alongside others;**
3. **Address the workforce implications of developing integrated services;**

[27] The 'Care at Home Workforce Project: identified issues and possible solutions – Your View' document is available to view from: http://wihsc.glam.ac.uk/documents/download/13/. The feedback is collated in 'Responses to Your View' and is available from http://wihsc.glam.ac.uk/documents/download/14/. We recommend that the documents are read in parallel in order to cross reference replies received in relation to specific issues, solutions or sections. If you have any queries or difficulties in downloading the documents (or would rather receive the documents on a CD-ROM) please contact WIHSC using the contact details at the end of this document.

4. Support the workforce in delivering outcome- and person-focused services;
5. Explore the workforce consequences of new service options around self-directed support.

Each of these Key Recommendations builds on the evidence presented in the previous sections. Importantly each of them has a potential and clear benefit, but there are costs attached to each of these changes. In places these costs and benefits will be well known but in others they will be less easy to discern. Cutting across all of this is the need to '*carer-proof*' these recommendations as advocated by the Carers' Strategy (Welsh Assembly Government, 2007c) to assess their impact on carers and to make adjustments where necessary given the significance of the unpaid workforce in securing the independence of so many vulnerable people at home. In the same way, each of the Recommendations are directly relevant to providers and their workforce. Rather than cite them each time in the '*Actions*' it should be understood that their involvement is central – where they are referenced they are especially important to the success of the issue at hand.

Furthermore it is essential that providers and care workers are engaged fully as this agenda evolves and decisions are taken about the changes discussed here. There is a need to establish and consolidate a comprehensive network/forum for regulated domiciliary care agencies in Wales, and their workforces, to assist in taking forward the vital work streams out lined in the recommendations. This project has begun this process of engagement and there is a role for the Care Council to continue this relationship, and begin to think through the implications for instigating a professional body to support the workforce in Wales.

1 | RECOGNISE THE VALUE OF THE CARE AT HOME WORKFORCE

This recommendation acknowledges the way in which care at home workers, in all sectors, have responded to the evolving challenges posed in meeting the support needs of vulnerable people. The response of such workers has often required the application of new knowledge and skills. The extent of that knowledge and the nature of those skills often go unrecognised and are reflected in the low status that is often ascribed to '*care jobs*'. Much of these changes have been made for little additional reward. Care at home services are perennially short of resources and need improved funding – however as an era of cuts begins, there are real fears that what is already stretched will need to be stretched further.

1.1 It is recommended that the terms and conditions of care at home workers are reviewed to ensure that they are being appropriately remunerated for the job they do.

There are a number of reasons as to why front line care workers will receive different terms and conditions for the jobs they do – qualifications obtained, years of service, who their employer is. In view of the changing nature of the work and the challenges that face them, there is an opportunity to recognise the key role that is being played by these care workers through reviewing their terms and conditions. This process would potentially enhance their status as professionals in knowing that their role is valued. We acknowledge that reviews of terms and conditions by individual employers may lead to a greater number of pay rates for ostensibly the same job which could actively undermine the principle of '*one sector, one workforce*' and lead to an undesirable increased turnover of staff between employers. This is to be avoided but, that said, we recognise that the local authority job evaluation process is one over which in-house employers have little control.
[Action – Assembly Government, commissioners, service providers]

[28] A number of these recommendations were raised in the 'Your View' document referenced in Footnote 27. Appendix 11 provides a cross reference between the recommendations made here and the solutions identified there. Further, Appendix 12 analyses the implications of the recommendations on the NOS.

1.2 It is recommended that strenuous efforts are made in securing new recruits and retaining the employment of those already working in the sector.

In a society where increasing numbers of vulnerable people are supported at home, it is essential that endeavours are made to ensure their inclusion where appropriate, in family, community and economic life. If the care at home workforce is devalued, then so is the status of those for whom care and support is given. Adoption of a Red, Amber, Green system (like that suggested in Box 7) could help retain staff. Should there be sufficient resource available, and should the outcome from '*Paying for Care*' justify it, consideration should be given to a campaign that bears testimony to the importance of the role of care and support workers (including PAs), which signals the career opportunities that can be harnessed, and helps recruit to the care at home workforce. Further it is recommended that the proposed Standard 12 of the new Commissioning Guidance must be used to ensure this is delivered.
[Action – Assembly Government, Care Council, local authorities, service providers]

1.3 Following from the above, it is recommended that the registration of care at home workers (including PAs) is achieved as soon as is practical.

Whilst the Care Standards Act 2000 requires that the Care Council '*make provision for the registration, regulation and training of social care workers*' as of yet no dates have been set for the care at home workforce (except managers of domiciliary care services who will be registered by July 2012). If implemented it is anticipated that registration could offer:

- different registration '*classes*' according to the responsibilities of, and roles carried out by, care at home staff (e.g. PA, care/support worker, direct front line manager or service manager);
- role profiles for each registration class, indicating the mandatory and optional NOS and the recommended qualifications for each class;
- the facility for registered practitioners to record the NOS they are competent in and the date their competence was accredited;
- a requirement for registered practitioners to comply with Codes of Practice that are relevant to their roles (whether relating to social care, health, housing or other support);
- a requirement for registered practitioners to fulfil conditions under a framework for their continuing professional development. Amongst other things this should include:
  - regular professional supervision;
  - a personal development plan which is reviewed with their line manager at least once per year; and
  - a career progression ladder showing the links between the role profiles in each class;
- recognition of the contribution made by care at home staff to both the social and health components of personal well-being; and
- links to local and national training provision leading to accreditation of competence in the various NOS or QCF units which might take the form of a tracked training and development portfolio.

The nature of registration and the detail of its implementation – like the potential charge, the relationship between registration and disciplinary action, and the potential role for a professional body for care at home workers, for example – have yet to be worked through and should be subject to a detailed further study. That said, whatever future decisions are taken about regulation and registration it would be expedient to consider proposals against the five principles (of proportionality, accountability, consistency, transparency and targeting) and test questions established by the Better Regulation Task Force and validated by the Better Regulation Commission and Risk and Regulation Advisory Council (see Section 2.1.3) and in doing so to ensure full account of the costs and benefits are considered. It is also important to see this in the context of the evolving regulatory landscape in Wales, and care should be taken to avoid duplication with the implementation of the Vetting and Barring Scheme.
[Action – Care Council, Assembly Government, service providers]

1.4 Acknowledging that registration will take a significant amount of time to achieve, it is recommended in the meantime that a National Minimum Dataset for care at home in Wales is developed as quickly as possible.

The best estimate available acknowledges that there are circa 15,500 care at home workers in Wales – 6,857 employed by local authorities and an estimated 8,727 in the independent and third sectors. There are real threats to care at home in Wales if it is not possible to more accurately determine the current level of the workforce, its qualifications, skills, demographic profile and other characteristics. This situation is especially grave in the independent (private and third) sector, and for a potentially growing number of PAs. A precondition of registration is that we will know more about the workforce, but given the immediate uncertainties about the future remedial action must be taken in lieu of registration in order to provide an accurate picture of where we are now, and where we might need to get to in order so that effective planning can be undertaken.
[Action – Assembly Government, CSSIW]

1.5 It is recommended that the funding for training all staff – front line care workers, managers (including supervisors and direct service managers), co-ordinators and commissioners – be reviewed and that action is taken to ensure that workforce skills are augmented and their further development is supported.

Given the dearth of information about the levels of training of the workforce it is not possible to ascertain the degree of training across the sector. One of the outcomes of this will be to point to the adequacy or otherwise of training and the funding arrangements underpinning it, including that for PAs. There are potential financial implications of understanding this position more clearly – the review may well identify a need for more training and therefore not be cost neutral. The importance of a secure and non-violable fund for training has been recognised in England where the Sector Skills Council has a budget – this situation should be replicated in Wales.
[Action – Assembly Government, Care Council, local authorities, service providers]

1.6 Subject to the outcome of the current review of In Safe Hands, and linked to Recommendation 1.3, it is recommended that efforts are re-doubled to ensure that the workforce is properly trained (and updated) in this important area.

Care at home workers have important roles to play in the protection of vulnerable adults. There is considerable concern that the abuse of vulnerable adults is under-recognised and -reported, and care at home workers are a vital source of intelligence in relation to potential abuse. All workers should therefore continue to be trained in the nature of such abuse, how to recognise it, and what to do if they have suspicions that abuse may be taking place. Particular attention should be given to PAs in this regard, since their relative isolation within the protection structures may make the reporting of abuse more difficult for them.
[Action – Assembly Government, commissioners, service providers]

1.7 It is recommended that Assembly Government closely monitors the impact of the new Commissioning Guidance on the delivery of care at home services in Wales and on achieving a quality, sustainable workforce, enforcing the new standards wherever necessary.

The Low Pay Commission (2009) argued that the commissioning policies of local authorities should reflect the actual costs of care, including the National Minimum Wage'. The standards of the new Commissioning Guidance in Wales provide an opportunity to realise this agenda if they are fully implemented – monitoring and enforcement are key aspects of any such implementation.
[Action – Assembly Government, CSSIW, commissioners]

2 | ENHANCE THE ROLE OF THE WORKFORCE IN ASSESSING NEEDS, PLANNING, COORDINATION, REVIEWS AND WORKING ALONGSIDE OTHERS

This recommendation responds to the clear need to move from what may sometimes be regarded as overly prescribed and narrowly task driven roles for care and support workers to ones that are more choice and opportunity driven. This reflects the need for more flexible approaches involving partnerships that can deliver on well-being (with both its social and health components) as well as supporting '*activities of daily living*'.

2.1 It is recommended that an enhanced role for care/support workers (and their direct managers/supervisors) in assessment, planning, signposting, co-ordination and review of service users' and their carers' and families' needs is promoted.

Given the vulnerability and varying needs of people supported by the care at home workforce, it is unsurprising that much is done that does not closely '*fit*' with prescribed packages of care. Some care workers (those working in an outcome-focused way, or those providing assessments of need for example) are remitted to be flexible – and are involved with the user in reviewing needs, planning support and care, motivating users, monitoring (with users and carers) their progress towards agreed outcomes. They offer, in their approach, a striking counterpoint to others who are permitted only to perform key tasks. The discretion (and, therefore, responsibility) afforded to such staff can be regarded as linked to an increased value placed on the role of frontline care workers and managers as indicated in Recommendation 1. Wherever necessary the role enhancement should be developed in partnership across health and social care to achieve the common goals of well being and independent living.
[Action – Assembly Government, commissioners, service providers]

2.2 It is recommended that new NOS are developed describing the new functions in the expanding role of the care at home workforce.

Specifically linked to the above, a new Level 3 NOS should be developed (building on HSC25 Carry out and provide feedback on specific plan of care activities) covering this broader remit. This NOS should be introduced into the care/support worker's role profile, initially as optional. Further NOS might also be appropriate based on HSC328 (Contribute to assessing the needs and preferences of individuals) and relating to the role of care at home workers in care/support co-ordination. More broadly in a context where greater skills and knowledge are linked with more complex needs of vulnerable people it stands to reason that some care at home staff will wish to specialise in ways that will relate to particular support needs. Examples would include those who support people with vision impairments, learning disabilities and dementia.
[Action – Care Council as part of Skills for Care and Development]

2.3 It is recommended that the role of carers is more actively supported by front line workers and others to enhance the quality of care for service users.

A recommendation made to the Care Council by Rowett et al (2009) in relation to working with older people experiencing dementia suggested that involving carers more actively in the care provided is often not straightforward, and issues such as liability, risk assessment, and inflexible structures can get in the way of creative solutions. Further that more needs to be done to enable sharing of personal histories and current care preferences, as well as recording information appropriately. Research from this study would confirm that hypothesis and if implemented, Recommendation 2.1 above would go some way towards achieving this, but here we recognise the breadth of the challenge and the key role of care workers in acting as effective signposts to other services.
[Action – Care Council, key stakeholders including carers, providers]

3 | ADDRESS THE WORKFORCE IMPLICATIONS OF DEVELOPING INTEGRATED SERVICES

This recommendation responds to concerns about the compartmentalisation of care at home within service and professional silos. As recognised in the '*Rural Health Plan*' (Welsh Assembly Government, 2009d), '*despite the progress made in service integration and joint commissioning, health and social care sectors still have difficulty in understanding each other's context, culture and financial and governance constraints*'. The call for integrated services reflects recognition of the need for them not just to be person-focused but to respond to user and carer choices. Integration means the development of frameworks and nurturing of skills that cross divisions between social care, health, housing and others.

3.1 It is recommended that qualification and training schema are developed that will support the development of new types of worker like cross boundary (generic) support workers and the extension of current care at home roles into areas like re-ablement.

Delivering services in new ways means that appropriate training (as well as service visions) must be in place. The opportunity to work more effectively across service boundaries requires that frameworks for training and skills development must change. Imaginative planning and means of delivery is needed in relation to generic educational courses and qualifications, and training programmes will be needed to develop appropriate skills to meet these needs at all levels.
[Action – Care Council, service providers]

3.2 It is recommended that the regulatory requirements for the new types of worker advocated for care at home are explored as a matter of urgency.

In order to secure both the workforce and those for whom they are caring, discussions need to take place in order to develop an appropriate and accountable regulatory framework for these new roles given their centrality to delivering effective care at home in Wales, both currently and into the future. Negotiations about the implications of these roles with regulatory/ professional bodies representative of those at the vanguard of these developments are now necessary, and are possibly overdue.
[Action – Assembly Government, CSSIW, Care Council, healthcare regulators and professional bodies]

3.3 It is recommended that those leading work across boundaries (whether between health and social care, or within sectors) relieve a number of the persistent pressures experienced by the workforce through the instigation a series of workstreams.

The principles behind the Memorandum of Understanding '*Securing Strong Partnerships in Care*' (Welsh Local Government Association et al, 2009) need to be translated into local, practical action. Key areas for consideration in workstreams designed to secure more integrated partnerships

- across and within sectors – include:
- medications (recording, compliance and administration);
- common language and shared understandings of contested terms (relating to things such as re-ablement, rehabilitation, intermediate care, empowerment and choice);
- ensuring all relevant stakeholders meet the requirements of the relevant partnership working NOS;
- establishing clear information/data collection and sharing protocols, building on the WASPI framework;
- support services that provide '*that little bit of help*' (befriending, community support, domestic assistance and others) that have benefits for service users, and by extension for both health and social care systems by

preventing escalation of need;

- developing a single health and social care record for use in the home by the individual, carers, care workers and health professionals;
- better local '*intelligence*' sharing about key services so that those working at the front line are more effectively able to signpost service users across sectoral boundaries.

[Action – Assembly Government, local health boards leaders, local authority leaders]

3.4 It is recommended that partners responsible for developing services within the care at home environment undertake workforce planning across both health and social care settings to maximise the opportunities to develop a more flexible health and social care workforce for the future.

Recent work to develop the new integrated workforce planning process for NHS Wales has pointed strongly to the key interface across health and social care in terms of workforce planning. The Assembly Government sanctioned workstreams which will take this work forward offer an excellent opportunity to discuss with partners ideas for integrating workforce planning procedures.
[Action – Assembly Government, Care Council, NLIAH]

4 | SUPPORT THE WORKFORCE IN DELIVERING OUTCOME- AND PERSON-FOCUSED SERVICES

This recommendation responds to the need to counter the worst effects of task driven approaches where few or limited choices are available for users and carers. It underpins the notion that person-focused outcomes must expand those choices and should relate, in key respects, to user rather than management outcomes.

4.1 It is recommended that the Care Council, working within Skills for Care and Development, should review the NOS, QCF, training and skills for commissioners, service managers and front line workers to ensure they effectively underpin outcome-focused working.

This is to ensure they are fit-for-purpose given the challenge of the move towards supporting outcomes-focused working and embracing any new or extended areas of required competence. Some changes may be required to existing NOS, and/or a new NOS may need to be developed covering the function: Support individuals to work towards targets for improving their health and wellbeing. Complementary actions that are addressed towards the needs of care at home workers will help commissioners and service managers to develop their competencies in relation to new service approaches and frameworks.
[Action – Care Council]

4.2 It is recommended that decisions about care packages are always taken in a collaborative way such that service users, carers and the workforce are as fully engaged in these decisions as possible.

Outcome- and person-focused service delivery requires much closer attention to be given to the needs of both users and carers, as well as fundamentally changing the nature of the relationship. If the new model of working is to be truly co-productive, with benefits for service users and care workers, a step-change is needed in the partnership between those commissioning, those assessing, those providing and those receiving care. One example of mutual benefit to all is that working in an outcome-focused way typically means longer visits with service users in order to derive better outcomes. In turn this means less travel time for workers between visits, which has a benefit for the provider as well as a potential benefit for those commissioning services.
[Action – Assembly Government, local authorities, service providers]

4.3 It is recommended that the workforce uses a standardised set of processes and accompanying documentation in assessing, reviewing and delivering outcome-focused services.

Whilst there are a number of piecemeal attempts to develop processes and supporting documentation, currently there is no single system for use in Wales. Producing assessment processes, care plans, daily records and review documentation and thereby establishing common process for OF working for Wales would remove any number of potential barriers. The driver for agreeing a single set of processes and documents would be to get the highest consistency and quality of assessment and reporting rather than every local authority and/or provider having its own systems. This would improve care, save administration and cost, and establish a consistency of approach across the whole of Wales.
[Action – Assembly Government, Care Council]

5 | EXPLORE THE CONSEQUENCES FOR THE WORKFORCE OF NEW SERVICE OPTIONS AROUND SELF-DIRECTED SUPPORT

This recommendation acknowledges that as the expectations of users and carers change, new service norms and practices will be established. These norms can provide challenges for some providers who have been used to doing things in traditional ways. They directly follow, however, from the agenda associated with personalisation, a key aspect of which relates to self-directed support.

5.1 It is recommended that the Assembly Government and/or Care Council publish accessible guidance to assist the workforce to understand the options available to service users and carers for self-directed care.

The wider development of service frameworks to facilitate self-directed care and support reflects the move towards partnership working between service providers, and a different relationship between service users and all others involved in their care. There may be a key role to be played here for (often voluntary sector) agencies that already have specific and relevant expertise.
[Action – Assembly Government, Care Council]

5.2 It is recommended that the Care Council commissions work to identify the competencies needed by service users in order to commission and manage their own care/support.

Those competencies will vary according to the model of service delivery chosen – extending from the user acting as employer to the user being able to make informed choices about allowable services within their own budget for care. The idea of an NOS/QCF unit covering the functions that service users need to carry out as employers (and the related training), including interviewing skills, should be explored.
[Action – Care Council, service providers]

5.3 It is recommended that the Assembly Government gives encouragement and appropriate support for trialling (and evaluating) forms of self-directed support.

The notion of self-directed support should not be seen as just relating to individual users and their carers. Some of the necessary flexibility in care at home that is being called for might be able to be delivered on a local basis. Insofar as aspects of self-directed support may result in increased personal well-being (including better health); more active engagement; and a reduced call on social care, health and housing services; the promotion of services in this way may respond to some of the concerns and issues being debated around '*Paying for Care*'. Ways of delivering care at home services that should be fully explored include '*Microboards*' and the development of local co-operatives.
[Action – Assembly Government]

5.4 It is recommended that the frameworks for training care at home staff, managers and commissioners take account of and support the further development and integration of assistive technologies.

Self-directed support demands that users and carers are able to make informed decisions about care and support services whether they follow traditional or newer patterns of provision. Such decisions may involve harnessing the potential of assistive technologies (including telecare and telehealth) that can reduce the need for care and support being delivered by care workers or carers. One example of this is that given an appropriate set of safeguards, 15-minute '*check*' calls could be superseded by telecare and telehealth technologies, which could have a series of benefits in releasing capacity within the workforce and realising cost savings for commissioners without negatively impacting hugely on service users for whom 15-minute visits are often unsatisfactory and sub-optimal.
[Action – Assembly Government, Care Council]

5.5 It is recommended that the funding for training PAs is made available in a timely and adequate manner ensuring that there is no shortfall between what is required and what is resourced.

The number of PAs is likely to increase as a consequence of more self-directed support. A significant number of current PAs report that they need to develop certain skills in order to become fully proficient in their job role. Compounding this, service user employers are generally unwilling to fund training for their employees frequently citing the prohibitively high cost. Funding for training does seem to be the main barrier to training provision. Access to training for PAs could be improved if extra funding for training were to be included in direct payments employers' support packages.
[Action – Assembly Government, commissioners]

Appendices

APPENDIX 1 | ORIGINAL TERMS OF REFERENCE

CONTEXT/BACKGROUND

The Workforce Action Plan arising out of '*Fulfilled Lives, Supportive Communities*' has identified domiciliary care as a crucial part of the sector in enabling people who wish to do so, to remain in the community. The increase in numbers of people remaining in their own home for longer has resulted in them receiving care which either they have commissioned or which has been commissioned on their behalf by others. Not all parts of this commissioned workforce lies within regulation at present. This has identified the need to ensure people who use services or employ people to work for them directly are safeguarded through a strong and effective workforce.

A smaller piece of work involving a survey of the domiciliary care sector is being undertaken by the Care Council at present and a report is expected on this by mid May 08. The survey identified the preferred means of communicating with registered service providers; the current level of qualification attainment within responding organisations for both managers and workers; the geographical spread of provision; the types of service provided; the length of staff service and various other issues.

AIMS, OBJECTIVES AND METHODS

- Establishing a Steering Group with a range of representation from interested organizations within the social care and health sector. The organizations should include representatives from local and national voluntary organizations, statutory and independent sector organizations, representative groups, large and small agency representation and colleagues from policy departments;
- Regular opportunities for discussion with formal written feedback provided at intervals and some review clauses noted to ensure both parties remain clear and happy with the way the contract is progressing;
- Gather a range of data and establish accurate information which will inform decisions about the regulatory priorities for the Care Council in conjunction with the Assembly Government;
- Establish a good rapport with the sector, together with a shared understanding of the benefits of registering Managers and Workers from this part of the sector with the Care Council;
- Identify the strengths and challenges faced by the sector in relation to:
  - the personalisation agenda, direct payments, supporting people, and generic workers – skills mix;
- Identify the numbers of staff employed in relation to the personalisation agenda, where, by whom, and the real/perceived vulnerabilities of both the employer and employee in such situations;
- Explore the skills issues at worker and managerial level emerging from above;
- Utilise an evidence based approach to examining the qualifications attained within domiciliary care and those identified for inclusion on the qualification framework;
- Identify the safeguarding issues for vulnerable people (children, young people and adults);
- Identify the issues for domiciliary care agencies at present, given the changing patterns of service delivery;
- Establish areas of work where commissioners, service providers and regulators might work in partnership to address some of the issues emerging and evident within domiciliary care at present. This would be in the interests of individuals who use services and their carers.

PRODUCT / OUTPUTS

Production of a formal report which identifies:

- workforce information about the sector and the range of services provided and by whom;
- the issues of concern and focus within the Domiciliary Care Sector;
- the issues of concern to/perspectives of people who use services;
- the views of other organizations and professionals working with domiciliary care agencies about the current issues (for example, commissioners, health colleagues, social workers, care managers, CSSIW etc);
- the process for identifying the required and recommended qualifications for registration;
- the current range of training / development opportunities available to workers within domiciliary care sector;
- the funding available within the sector to meet the above needs;
- the mechanism for sharing the outcomes of the project with the sector;
- An Action Plan identifying priorities and targets for addressing the issues within the report.

Care at Home: challenges, possibilities and implications for the workforce in Wales

APPENDIX 2 | OUTLINE METHODOLOGY

The context for the project was initially set out in the Scoping Report (February 2009) and in the Initial Report (April 2009). The latter was informed by an analysis of a number of different data sources, principal among which are the Local Government Data Unit (LGDU), and CSSIW date. It was also informed by the Workforce Visioning Event held in Llandrindod Wells (April 2009). Participants at the Visioning Event identified implications and actions for the care at home workforce that fell under six broad '*Visionary Statements*' for the future of care at home:

1. **Recognise and valorise the crucial importance of those in families and communities supporting those in need;**
2. **Move towards an outcomes-focused and personalised service for all care provided, regardless of circumstance;**
3. **Ensure financial viability of care and long-term sustainability of the workforce, through rejecting thinking about cost, and moving towards thinking about value;**
4. **Enable continuity of provision across professional boundaries;**
5. **Support care at home workers to provide the best care possible;**
6. **Promote independence and choice for service users, by placing them at the centre of all decisions about their care.**

In the summer of 2009 we undertook primary research with service users and carers, care workers, providers, managers, commissioners and other stakeholders in order to hear directly about the experiences of delivering and receiving care. It is important to note that whilst this included working across different client groups – acute and chronic illness, frailty, learning disabilities, mental health and physical disabilities and sensory impairment – the vast majority of the 160 service users we engaged with were older people (i.e. over 65 years of age).

Table A2.1 | Number of people participating in primary research to date

Service Users and Carers	Frontline workers and line managers	Others
160	119	17

The outcome from this phase of the study was reflected in an Issues Paper (July 2009) and the Mid Project Report (September 2009). These documents were followed by four Deliberative Workshops, centred on the workforce implications of four key themes which emerged through the course of the study, held during Autumn and Winter 2009-10:

DW 1 – Independence and choice for service users (Wednesday 14th October)

DW 2 – Provision across boundaries (Thursday 19th November)

DW 3 – Role and impact of families and communities (Tuesday 15th December)

DW 4 – Outcome-focused service provision (Thursday 21st January)

One of the principal outcomes of the study to date has been the production of the '*Your View*' document which has re-presented all of the issues and possible solutions that have been identified for overcoming them back to the 200+ people who have contributed to the project as a whole. The outcomes from that exercise have been reflected in the Recommendations made here.

Throughout the study, the Project Steering Group has been fully involved in decisions regarding the methodology and overall direction of the work.

APPENDIX 3 | SUMMARY OF MAIN COMMUNITY CARE STATUTES

It is estimated that there are currently over 30 Acts of Parliament dealing, to varying degrees, with adult social care. A fuller discussion of the development of adult social care can be found in Part 2 of the Law Commission's Scoping Report (Law Commission, 2008).

National Assistance Act 1948

Introduced by the post-war Labour Government, the NAA 1948 establishes a duty to provide residential accommodation and a general duty to provide community services to disabled people.

Health Services and Public Health Act 1968

The HSPHA 1968 gives local authorities a discretionary power to provide services "promoting the welfare of older people". This did not amend the earlier NAA 1948 but rather establishes a separate statutory power to provide services.

Chronically Sick and Disabled Persons Act 1970

Originally a Private Member's Bill, the CSDPA 1970 augments the general duty in the NAA 1948 to provide community services. It provides a strong duty to provide services to disabled people. The CSDPA 1970 did not amend the NAA 1948 but instead operates in parallel.

Mental Health Act 1983

Section 117 places a strong joint duty on health and social services to provide after-care services to certain former mental health patients.

Disabled Persons (Services, Consultation and Representation) Act 1986

Originally a Private Member's Bill, the DP(SCR)A 1986 introduced a right for disabled people to request an assessment under the CSDPA 1970 and places a duty on local authorities to have regard to the needs of the carer when deciding which services to provide for a disabled person. It did not, however, amend the CSDPA 1970.

National Health Service and Community Care Act 1990

The NHSCCA 1990 introduced a right to an assessment for community care services and gives social services the responsibility for assessing need and arranging a package of care services. It did not consolidate any of the previous legislation.

Carers (Recognition and Services) Act 1995

The C(RS)A 1995 places a duty on local authorities to carry out a carer's assessment where the cared-for person is being assessed under the NHSCCA 1990 or Children Act 1989.

Carers and Disabled Children Act 2000

The CDCA 2000 gives carers a free-standing right to an assessment, independent of the assessment of the cared for person and gives a power to provide services to carers. It operates in parallel to the C(RS)A 1995.

Community Care (Delayed Discharges etc) Act 2003

The CC(DD)A 2003 establishes the delayed discharge regime, which imposes time scales for assessments of NHS inpatients and fines if a delay in discharge is caused by social services.

Carers (Equal Opportunities) Act 2004

The C(EO)A 2004 amended (but did not consolidate) both the C(RS)A 1995 and the CDCA 2000 by providing a number of new rights for carers.

NHS Act 2006 and the NHS (Wales) Act 2006

The NHS Acts 2006 place a general duty on local authorities to provide community services for "the prevention of illness and for the care of persons suffering from illness and for the after-care of persons who have been so suffering".

Source: Law Commission (2010) Adult Social Care: a consultation paper Consultation Paper 192, London: p.viii-ix

APPENDIX 4 | KEY PARAMETERS

FUNCTIONAL ABILITY

Service frameworks in the past and certainly from the 1970s onwards have tended to view domiciliary care over-narrowly in terms of these (Watson and Albrow, 1973; Bytheway, 1979). The breakout from a narrowly task-focused perspective was signalled in the Welsh Office document '*A Good Old Age*' (1985). This was intended as providing an '*impetus for action*' and sought '*a tangible shift in emphasis in the provision of services for the elderly*'. Importantly it affirmed a primary objective as to '*promote and maintain…independence*' and suggested that '*assistance should be designed to extend the elderly person's abilities by way of compensation and rehabilitation, rather than to offer patterns of care which might encourage or reinforce dependence.*' Joint provision of services by health and local authorities was seen as '*vital*'. These prescient themes from 1985 echo those which underpin current strategic frameworks.

SAFETY

The issue of people's safety has, of course, been a long-standing theme which must be reflected in the way that services are configured and delivered in the home. The issue is now of greater importance in view of the increasing number of people who can be deemed vulnerable and who are being supported at home. There are, of course, tensions between the idea of '*protection*' (in order to ensure a person's safety and security) and that which fosters independence and greater autonomy. Provision of the former is both a practical and humane response to the needs of those who by virtue of age, illness or disability are vulnerable. The context, however, is one where the pursuit of independence and autonomy can carry higher levels of risk.

Safety in the home remains a matter of considerable concern and there are key aspects of legislation, aside from those in civil and criminal law, which relate to this. In the home we can note that the '*Housing, Health and Safety Rating System*' (Department for Communities and Local Government, 2006) is concerned with '*avoiding, or at the very least, minimising potential hazards*' and the '*risk of harm*' from any deficiency that can give rise to the same. This embraces physiological and psychological requirements, together with protection against infection and accidents. A further dimension is the notion of '*insuring*' against future risk – providing mechanisms to ensure that people who are currently safe can cope with any future eventuality that might threaten their safety. For example, many older people are concerned about what might happen to themselves or a partner for whom they care if their physical or mental health were to deteriorate rapidly at some future date.

Related legislation reflects a strategic perspective that not only is concerned with enabling people to stay in their own homes but also affords them additional protection in order to do so. There is, in this context, growing support for care and repair agencies by the Assembly Government in Wales and in the more emphatic developments in England around the '*Future HIA*' (home improvement agency) project (Department for Communities and Local Government, 2008). Hence safety is affirmed as a key parameter in this study and is a matter that must be considered in relation to strategic and operational service frameworks.

However the subject of safety has (in relation to abuse) been much addressed under the umbrella term '*safeguarding*' (noted below). Specifically regarding safeguarding, a useful overview of some of the issues for older people was provided by Age Concern Cymru (2009). '*Abuse*' in that overview, is defined by the Assembly Government (2000) as '*a violation of any older person's human and civil rights, by any other person or persons*'. This is valid, of course, at any age. A key point made in the document is that abuse can take place in any context, and uncomfortable though it may seem, abuse is recognised as taking place within families and is perpetrated by a small minority of staff to whom people's care is entrusted. A major UK study, for example, found that 2.6% of older people reported that they had '*experienced mistreatment involving a family member, close friend or care worker*' (O'Keeffe et al, 2007). Women more than men were affected and the proportion was especially high for those who were separated or divorced. 13% of reported incidents of mistreatment in the previous year were perpetrated by a care worker.

A five-fold classification of abuse was adopted in the O'Keeffe study. This embraced physical, emotional, sexual and financial abuse together with neglect. Neglect, in the study, had the highest prevalence rate (at 1.1%). An overall higher rate of

abuse on the basis of 326 personal interviews with people aged over 65 was identified for Wales (at 3.1%) again with neglect (at 1.8%) the most prevalent. Those in the poorest health and/or with long-term illnesses were more likely to report abuse. According to evidence presented by Action on Elder Abuse to the House of Commons Select Committee on Health, paid carers represent 31% of abusers. There can be, at the same time, shortcomings in complaints systems and those who are abused may not know to whom to turn (Bright, 1997). Age Concern Cymru (2009) broadened the categories of abuse and gives '*possible indicators*' for each type. Heightened awareness of the issue is clearly a pre-requisite for it being addressed.

It follows that the regulatory frameworks for domiciliary care will need to take account of such matters. They will also need to consider the outcomes of the recently completed Assembly Government's review of their '*In Safe Hands*' guidance (Welsh Assembly Government, 2000). The Assembly Government's '*Dignity in Care Programme*' aiming at '*zero tolerance of abuse and disrespect of older people*' is clearly also important in this context and will be central to a range of different service standards. This programme points to the Care Council's responsibilities regarding the dignity agenda in relation to training and staff development matters.

Abuse is far from being confined to older people. Referrals for abuse in the Caerphilly Borough Council area in 2005/06 showed not dissimilar numbers of younger adults who experienced abuse. Of all the referrals in that study some 40% of '*incidents*' took place in people's own homes. A further 40% took place in a residential or nursing home.

The seriousness with which the Assembly Government takes this issue is reflected in their establishing (following the precedent set by the Children's Commissioner) the office of the Older People's Commissioner for Wales. One of the Commissioner's main roles is to '*safeguard the interests of older people throughout Wales*' and among their guiding principles is the '*right of older people to dignity and respect*' (Older People's Commissioner for Wales, 2008). Recent legislation, furthermore, that helps in the regulation of domiciliary care and other services for vulnerable people recognises the issue as affecting adults of all ages.

Within the umbrella term of '*safety*' is recognised the importance of safeguarding. The tension between ensuring safety and supporting independence (with its associated risks) we recognise as an enduring one. It points to the importance of vulnerable people being supported in making their own (informed) decisions on such matters.

PERSON-FOCUSED SERVICES

The strategic policy emphasis on attaining person-focused services has been constant. As well as '*Our Health, Our Care, Our Say*' (Department of Health, 2006) and '*Putting People First*' (2007) has been published '*Improving the Life Chances of Disabled People*' (Cabinet Office, 2005). At its heart is the clear affirmation that services must be centred on the person; and the person must have real choices about the services they access. Further control over services is obtained by users through direct payments – whereby people can receive a cash sum in order to pay for their own services. Direct payments, of course, give people more control of their care and support but (as noted below) also present a number of challenges, including the engagement of personal assistants. A variant of direct payments are individual budgets where sums are held (and spent) on behalf of the service user, but where a greater degree of responsibility (e.g. in matters of contracting) is retained by the service provider.

The idea that services should be person-focused is, of course, nothing new. This approach to services encourages the creation of new mechanisms that make a reality of strategic objectives relating to empowerment and, in so doing, really put service users more in control. This has major implications for the traditional case (or care) management approaches that have pervaded domiciliary care. It suggests a care management approach in the future that is more concerned with information, facilitation and signposting. There are '*onward*' implications for the roles of domiciliary care workers, their skills, training and, where appropriate, regulation.

Reviews of initiatives relating to direct payments and individual budgets to date give pointers as to the potential and the problems. Davey et al (2007) in reviewing policy and practice relating to direct payments found most such schemes directed at or taken up by people with a disability or sensory impairment. There was steady but unspectacular growth in the number of people supported in this way. For Wales, albeit based on the responses from just three local authorities, the average number of people with direct payments was a mere 17. Three quarters of these were for people with a physical disability or sensory impairment. The review concluded that '*as yet, there is little evidence that direct payments are transforming commissioning strategies, except in areas of the highest uptake.*' The review did not comment on, however, the extent to which people receiving direct payments were empowered through them. Davey et al (2007) did, however, make some pertinent points about direct payments in their more discursive '*policy and practice recommendations*'. Based on the UK as a whole, these included:

- the increasing diversity of users;
- staff resistance being a '*significant barrier*' to implementation;
- the tendency for their use by people with '*high-intensity*' packages;
- needing mechanisms to be introduced whereby the nursing care can also be bought in;
- the position of Wales, Scotland and Northern Ireland as lagging behind England; and
- the lack of impact, to date, on commissioning strategies.

In a more outcome oriented review of 13 pilot individual budget initiatives in England, Glendinning et al (2008) found evidence that many recipients felt more in control and, in some cases reported a higher quality of life. The pilots were directed at a wide range of user-groups (including those with a physical disability or learning disability, and older people) and ongoing research is examining both outcomes and costs. In the meantime we note both the indicated positive outcomes for users; and the fact that in these pilots, there was little difference in the cost of individual budgets when compared to '*conventional social care.*' Of significance is their finding that the greatest successes encountered with regard to individual budgets were associated with the drawing together of different funding streams. But as with direct payments, the exclusion of funding for healthcare was noted. This was pointed to as a source of staff frustration and '*considered incompatible with the holistic individual budget philosophy*'. Relevant to this study is their affirmation that '*clarity is needed on the appropriate uses of individual budgets and on the legitimate role of adult social care funding, given the twin pressures of responding creatively to individual needs on the one hand and safeguarding vulnerable adults on the other.*'

Some consideration of these issues has been made by James (2008). In considering the options for Wales, she warned of some of the dangers that could accompany direct payments. These centred on the consequences of people engaging '*unregulated and untrained*' workers for their support. She argued for the need to '*reframe social care service users as citizens with rights [which] should heighten rather than diminish the commitment to ensuring safe and quality care for those who are dependent on others for personal assistance.*'

ABLEMENT

The fourth parameter is that concerned with ablement. It represents the natural destination for service development as indicated in Figure 2 and will, when and if achieved, represent a realisation of many of the oft stated goals of care at home.

The term '*ablement*' (rather than re-ablement) is chosen deliberately in order to affirm the need for services to help people maintain (or build on) the levels of independence that they have. Re-ablement implies a mechanism of recovery that relates to the effects of adverse personal circumstances. The notion of ablement reflects the views and wishes expressed by a majority of service users, and their carers.

Independence (a clear outcome of ablement), however, is a problematic concept which changes its meaning according to the person's circumstances and aspirations. Personal interviews with nearly 150 people aged 75 and over (including 43 in Wales) found a number of key themes including the importance of deciding things for yourself (Abbott and Fisk, 1997). The point was emphatically made that independence is '*not solely determined by an individual's ability to undertake day-to-day living tasks…it also reflects the individual's personality, attitudes and motivation; (their) financial resources and his/her control over them; (and) the physical and social*

context.' Related to this were people's strategies to overcome the challenges associated with disability and illness and the various other barriers with which they are faced. Control is an issue that is often even more emphatically raised by younger disabled adults (see Institute for Public Policy Research, 2007).

The key point here is the need for the domiciliary care workforce to support independence: not in relation to some basic level of personal functioning; but in allowing individuals to reach an optimal level determined by themselves in light of both the services and opportunities available to them. Supporting independence therefore moves from being a rather limited concept to one which is actually concerned with empowerment and, using our term, ablement – so that people are helped to maintain, increase or regain an ability to engage at the level they would wish in family, social, community and economic life.

The term re-ablement has been in relatively common use within the sector. Indeed, aside from the day to day delivery of '*re-ablement*' services by different authorities in Wales, there are nine re-ablement initiatives which the Social Services Improvement Agency is currently sponsoring. Outcomes from these pilots include the development of a single framework for '*good re-ablement practice*' and the production of a '*re-ablement resource document*'. Regardless of whether the term ablement is adopted more broadly, it is important to question the extent to which domiciliary care should or could be involved in ablement and, indeed, in activities that support empowerment.

With regard to the same we would draw attention to a range of (relatively new) initiatives that have been developed to encourage people to adopt healthier lifestyles that can underpin their achieving greater independence. Integral to these are matters relating to medication compliance, therapies, engagement in social and other activities, improved nutrition, taking exercise, etc. One such initiative is the '*wellbeing-support*' programme run in Merthyr Tydfil (one of eight centres in England and Wales), and following positive outcomes is being explored by health trusts elsewhere. Another is the Birmingham '*OwnHealth*' initiative offering '*motivational support*' for people with long-term conditions. Yet another is the '*active support*' approach being promoted by ARC Cymru for people with learning disabilities. The question arises as to the extent to which domiciliary care workers (and those that work elsewhere in social care) can be equipped to operate in this domain, supporting healthcare (with appropriate clinical or nursing guidance), being aware of and signposting service users to other sources of support, and helping to promote broader well-being.

Care at Home: challenges, possibilities and implications for the workforce in Wales

APPENDIX 5 | WORKFORCE DATA

Tables A5.1 and A5.2 are drawn from Social Services Statistics Wales, 2007-08 (Local Government Data Unit, 2009).

Table A5.1: Home care staff, at 31st March 2008 [a, b]

	Staff with required or recommended occupational qualifications	Other staff	Full time	Part time	Total	WTE
2005	1,728	6,172	1,098	7,045	8,143	4,587
2006	1,952	5,868	1,130	6,704	7,834	4,544
2007	2,609	4,491	918	6,676	7,594	4,256
2008	3,107	3,351	1,102	5,755	6,857	4,455

(a) Home care staff for adults and children

(b) The sum of staff with required and recommended qualifications and other staff does not equal the total number of staff due to duplication across categories and missing data from some areas

Table A5.2: Domiciliary service staff, number qualified at 31st March 2008

	2005		2006		2007		2008	
	Qualified staff	Total Staff	Qualified staff	Total Staff	Qualified staff	Total Staff	Qualified staff	Total Staff
Domiciliary services for adults								
Managers and deputy managers	62	143	76	165	94	197	102	186
Senior domiciliary care worker, family aide	122	358	114	358	137	360	175	384
Domiciliary care worker, family aide	1,472	6,932	1,710	6,725	2,256	6,497	2,685	5,772
Domiciliary services for children								
Manager and deputy manager	6	16	2	10	5	9	8	12
Senior domiciliary care worker, family aide	8	15	3	9	6	10	6	8
Domiciliary care worker, family aide	58	679	47	567	111	521	131	495

Tables A5.3-A5.6 are drawn from First Release - Assessments and Social Services for Adults, 2008-09, published 24th September 2009 (Statistics for Wales, 2009).

Table A5.3: People receiving community-based services at 31st March 2009

	2007	2008	2009
Homecare	26,215	25,425	25,685
Day care [a]	15,942	16,228	15,847
Respite care	2,443	2,910	3,592
Reablement [b]	359	777	803
Meals	8,595	8,243	7,759
Equipment [c]	21,709	24,402	28,717
Adaptations [d]	9,490	9,876	10,184
Direct payments	1,277	1,540	1,991
Supported accommodation	2,184	2,452	2,531
Adult placements [e]	200	309	288
Total number of people receiving services [f]	**66,122**	**66,523**	**67,433**

(a) Traditional day care in day centres and community support day care provided outside the home
(b) 2008 based on data provided by 21 authorities
(c) Where there is an on-going financial commitment by the local authority, e.g. maintenance
(d) 2007 and 2008 based on data provided by 21 authorities
(e) 2007 based on data provided by 21 authorities
(f) Total number is less than sum of categories because some people receive more than one service

Table A5.4: Average hours of home care received in sample week, by age group [a]

	Age 18-64	Age 65 & over	All ages
Number of hours	77,071	153,378	230,449
Number of clients	5,041	18,562	23,603
Average number of hours per client	**15**	**8**	**10**

(a) Hours are counted from the client's perspective, e.g. .if two members of staff are present during one hour, only one hour of service is counted although two hours of staff input are provided.

During a sample week in September 2008, 23,600 people received home care – personal care in their own homes provided by social care workers. Over three-quarters of clients receiving homecare were aged 65 or older. On average, an individual aged 18 to 64 received almost double the hours provided to someone aged 65 or over.

Table A5.5: Home care hours provided in the year

	2006-07	2007-08	2008-09
Home care hours (millions) provided by:			
local authority staff [a]	6.2	5.8	5.2
independent providers	7.1	6.4	6.6
Total home care hours (millions) provided	**13.3**	**12.2**	**11.7**

(a) 2006-07 based on data provided by 21 authorities

The total of home care hours provided by local authorities in 2008-09 decreased by 4 per cent to 11.7 million hours compared with 2007-08. The decrease was due to a decline of home care hours provided by local authority staff as hours provided by independent providers increased. The proportion provided by independent providers under contract to local authorities increased from 52 per cent in 2007-08 to 56 per cent in 2008-09.

Table A5.6: People receiving home care services in the sample week, by hours of service received per week [a]

	Sept 2006	Sept 2007	Sept 2008
Less than 5 hours	10,348	9,917	9,358
5 hours and up to 10 hours	6,974	6,952	6,695
10 hours and up to 20 hours	5,328	5,418	5,436
More than 20 hours	2,178	2,175	2,114
Total number of people receiving services	**24,828**	**24,462**	**23,603**

(a) Hours are counted from the client's perspective, e.g. if two members of staff are present during one hour, only one hour of service is counted although two hours of staff input are provided.

Table A5.7 is drawn from KS08 Health and provision of unpaid care, Census 2001 (Key Statistics for Assembly Constituencies and Assembly Electoral Regions for the National Assembly for Wales). The table provides information on the health of and provision of unpaid care by the population of Wales. It covers the population '*all people*', and contains data for Assembly Constituencies and Assembly Electoral Regions for the National Assembly for Wales, as well as Wales as a whole. For this purpose data pertaining to carers and the amount of care they provide has been selected. In this table provision of unpaid care means looking after; giving help or support to family members; friends; neighbours or others because of long-term physical or mental ill-health or disability or problems relating to old age.

Table A5.7: Provision of unpaid care per week in Wales, 2001

	Number	%
People who provide 1-19 hours unpaid care	208,195 [a]	61.1
People who provide 20-49 hours unpaid care	42,934 [a]	12.6
People who provide >50 hours unpaid care	89,616 [a]	26.3
Total – all people who provide unpaid care	**340,745**	**100**

(a) These values have been calculated by the research team using the total and percentage values provided in the Census data.

Table A5.8: Average hours of home care received in sample week, by age group [a]	
Hours provided per week	
Those providing 1-19 hours unpaid care	208,195 [a]
Those providing 20-49 hours unpaid care	858,677 [a]
Those providing >50 hours unpaid care	4,480,797 [a]
Total	**5,547,669**
Hours provided per year	
Those providing 1-19 hours unpaid care	10,826,150 [a]
Those providing 20-49 hours unpaid care	44,651,225 [a]
Those providing >50 hours unpaid care	233,001,431 [a]
Total	**288,478,806**

(a) Calculation was made using the minimum values in the range i.e. 1 hour per week for those providing between 1-19 hours per week, 20 hours per week for those providing 20-49 hours per week, and 50 hours per week for those providing more than 50 hours per week

Table A5.9 compares the data from Tables A5.8 and A5.5 to estimate the proportions of care provided by those who are paid for and those who are not paid for. These hours exclude private payers who are not assessed by the local authority. They also, by definition, compare data from 2001 with that of 2007-8 which is not an ideal situation but is the best compromise available.

Table A5.9: Proportion of unpaid and paid care per year in Wales [a]		
	Number	**%**
Total annual unpaid hours of care	288,478,806	96.1
Total annual paid hours of care	11,700,000	3.9
Total – annual hours of all people who provide care	**300,178,806**	**100**

(a) Calculations were made by comparing data from Census 2001 with that from Social Services Statistics Wales 2007-8. Care must therefore be taken with the values as they do not compare the same time period.

APPENDIX 6 | WORKFORCE VISIONING EVENT – DETAILED INFORMATION FROM DISCUSSIONS

CHANGES IN DEMAND (e.g. demography, changes in expectations and resources)

High Likelihood, High Impact

Younger Dementia/Substance Misuse/Downs/Sports/RTA accidents/Autism/LD	Generally there would be an increase in young people with these different problems much related to current substance misuse (drugs and alcohol) and the ability to treat long term conditions
Needs for a flexible workforce – change in tasks undertaken	As the group agreed that person centred care should be a given with enabling tasks as a priority, there should be a flexible workforce to enable this to happen with varying levels of skill
The value/quality of services for the carer as well as the service user	It was essential to ensure that the carer wasn't forgotten in the person centred approach to care. It was felt that the carer and service user would demand an increase in quality as their expectations grew
Transition period	Area from children's services versus adult services. In order to achieve person centred care this area would require a seamless approach
Autonomy of service user	The ability to make decisions about his/her own life which was also seen as directly linked to individual dignity. This would occur as the service user group expectations changed
Self directed support	Cultural changes-issues of determination about what people want and how they want it delivered
Independence for older people	Cultural change as population demands this
Changed expectations of service user	Cultural change- directly linked to independence, knowledge and empowerment of the population

Medium Likelihood, Medium high impact

Balance of cost of less time to do for and initially higher cost of enabling	In general the debate centred around the shift in working practice and the need to spend to save
Demand should be measured by outcomes for people	The demand for services should be measured through outcomes and not through current methods
Outcomes	Effect of services on the totality of an individual's life

Low Likelihood, High Impact

Greater co-operation in delivering health and social services/ third sector, cost savings	The health and social care divide was felt to be artificial and not helpful when trying to manage complex needs. However this required organisational changes which the group felt were unlikely to happen
Individual budgets	Although the opportunities would be available, the numbers of people who would participate in this would remain small
Decline in residential homes and increase in extra care sheltered care housing schemes	This change would continue but would level out to have little impact within the next 10 years
Person centred	What would a person want from a service? Services provided tailored to meet these needs. Although this was highly desirable and would have a high impact, it was questionable because of the workforce's ability to deliver
Preventative focus: how does it fit?	Although the preventative side of the role of the care at home worker was considered an essential part, they didn't feel that this was an aspect that would happen in the next 10 years

CHANGES IN SUPPLY (e.g. skills, qualifications, telecare and other technology)

High Likelihood, High Impact

The group perceived that the following issues were likely to occur, and would have a high impact on the care at home workforce

Reconciling the skills overlap between health and social care	There will be a move to reconfigure professional boundaries if interventions like generic workers are to be taken forward, allowing the workforce to supply different services in a more continuously
Recognising that maintaining quantity will compromise quality	Given that there will inevitably be a fixed budget for care at home services, there is a danger that the range of service currently offered cannot be sustained. There is a risk that maintaining the broad spectrum of services will impact negatively on quality
Numbers of workers may not be adequate to supply the demand	Threat that the relatively low status of care at home workers, and the complex and challenging nature of the work they do, will mean there are insufficient numbers in future
Increasing role of family and other forms of care	There will be an increasing reliance on the informal part of the sector, with families and other carers contributing to more and more care at home
More appropriately targeted care	The ever-tightening eligibility criteria means there will need to be a much more effective way of ensuring that care is targeted appropriately, with the right skills in the right place at the right time
Recognising crucial role of the third sector	The third sector's role in care at home is already significant, and will clearly continue and be valued. One consequence of tightening eligibility criteria will be that there may be much more of a role for the third sector in providing care that once was commissioned but now is below eligibility criteria
Defining responsibilities in relation to finance	Pressure on public sector budgets will continue to dominate, resulting in prioritisation of cost savings over improved value for money. In addition there must be much more transparency over the relative roles and responsibilities in relation to finance
Outcomes-focus	Underpinning all of the discussion was a recognition that the move towards outcomes-focused working will have significant (and potentially positive) impacts on the workforce and their clients

High Likelihood, Low Impact

Technology (including assistive technologies, telecare and telehealth)	The impact that these technologies might have is somewhat over-estimated and until there are improved competencies, their impact will be limited
Identifying appropriate career pathways and opportunities for re-skilling workers	There is a need to professionalise the existing workforce without alienating many of those who have been doing the job for many years, and for whom more specialist care is not an attractive option. Linked is the need to be able to offer career pathways more explicitly than currently

Low(er) Likelihood, High Impact

There were no issues identified in the '*low likelihood, high impact*' category. That said there were a number of issues located in the middle of the likelihood axis which were clearly differentiated from the high likelihood, high impact issues:

Benchmarking payments / commissioning / procurement	There is inequity within the current arrangements which leads to inequality in services delivered. A benchmarked and equitable approach across Wales would go some way to reduce this
Benchmark qualifications and accreditation	As above it is necessary to ensure that there is parity between the same qualification gained from different institutions e.g. making sure an NVQ L3 means the same thing in practice wherever students have gained the qualification
Reflect status of work and workers in terms and conditions of employment	If the care at home workforce is to be a truly professional one which is increasingly required to provide increasingly complex care, this has to be recognised in real terms

Low Likelihood, Low Impact

No issues were identified in this section of the chart.

CHANGES IN POLICY (e.g. regulation, structure of health and social care)

High Likelihood, High Impact

The following issues were likely to occur, and would have a high impact on the domiciliary care workforce. Some represent continuity with the recent past, others a significant change in emphasis from recent policy.

Continuity

Continuation of low pay, low value	In general, domiciliary care worker pay rates would continue to be low compared with many health and other staff, reflecting their low 'status' in society
Continued dominance of a crude 'savings' agenda	Pressure on public sector budgets will continue to dominate, resulting in prioritisation of cost savings over improved value for money
No change in approaches to Procurement	Procurement processes in many parts of Wales would continue to be over-dominated by the imperative to achieve the cost reductions mentioned above, and would not be sufficiently responsive to quality improvement and innovation
Local variation in the application of national policy	National policy will be applied in significantly different ways in different parts of Wales, resulting in inconsistency, inequality and difficulty for suppliers operating across boundaries
Continuation of funding perversities	Funding for domiciliary care will continue to come from a multiplicity of funding sources, with little flexibility between the funding 'silos'

Change – with increased emphasis on…

Shift – Residential to Domiciliary Care	More care provided in people's own homes
Support for telecare	Policy will support much wider application of telecare
Support for carers	Carers will receive growing policy support
Cyclical emphasis on different client groups	Different client groups (e.g. older people, learning disabilities) will receive different policy priority at different points in future

High Likelihood, Low Impact

Increased emphasis on responding to diversity in clients and workers	Services will be encouraged to respond to a growing cultural diversity amongst both clients and staff

Low Likelihood, High Impact

Improved training opportunities	Training opportunities will not expand and improve as rapidly as they should to meet changing needs
Increased early intervention	Despite policy emphasis, it is relatively unlikely that there will be a major shift in provision to meet the needs of people before they become dependent

Low Impact, Low Impact

Increase in EU regulation	No immediate sign that the EU will assume greater competence in the regulation of home care workers
Increase in male domiciliary workers	Possible increase in male workers as a result of the recession, but this will probably not be sustained

Key Unknowns

For these issues, it was impossible to predict their likelihood or extent of their impact:

Personal budgets	The extent to which clients would assume control of their own budgets, or the use to which they would put this control
Paying for Care	Current consultation might have a substantial impact
Health and Social Care divide	Although the policy drive is towards bridging this divide, there are several imponderables which will affect the outcome (e.g. reorganisation of the statutory sector)

Care at Home: challenges, possibilities and implications for the workforce in Wales

APPENDIX 7 | DELIBERATIVE WORKSHOPS – SUMMARY

Deliberative Workshop 1 (14th October 2009)

INDEPENDENCE / CHOICE FOR SERVICE USERS – WORKFORCE IMPLICATIONS

Discussion Agenda

1. **Not being listened to**
   - Comment about how care is delivered
   - Limited input into care package decisions
   - Too much care being delivered
2. **Lack of flexibility in care packages**
   - Choice of provider and / or care worker
   - Timing of care
   - Additional tasks outside the care plan
3. **Language and cultural barriers**
   - Especially acute for those with specific language or communication needs
   - Need for greater cultural awareness and sensitivity to diversity issues in workforce
4. **Striking the appropriate balance between choice and responsibility**
   - Understanding the '*burden of independence and choice*'
   - Providing genuine workforce choice and moving beyond tokenism
5. **Risk averse practices – engaging effective risk management procedures**
   - Striking the right balance for care workers and service users
6. **Signposting towards available services and support**
   - Need for positive interaction and accurate knowledge and information

Key outcomes of the discussion

Attendees identified several areas where they felt improvements could be made in order to resolve or reduce the impact of the issues:

- Promote good practice in commissioning and procurement. Provide extra resources for care in the community by reconfiguring commissioning from acute to community workforce. CSSIW and the Assembly Government should ensure providers are paid a fair price for care through use of agreed costing model with providers;
- Listening to the workforce, two way communication process. This will require improved skills and attitudes of middle and senior managers;
- CSSIW should have a constructive part of their website to help providers understand the acceptable flexibility within the bounds of safe practice and the regulatory framework and promote good practice;
- Target future workforce through education e.g. promotion by careers advisors, inclusion in the national curriculum, clarifying baseline education and training requirements which are core for competence;
- Ensure all employers have direct access to training. A need identified for an effective sector skills council for social care sector to fight for necessary funding and distribute in return for NMDS data. Local authorities offer encouragement, incentives or rewards to providers. Clarify whether local authority contracts pay for costs of releasing staff for training or whether there are incremental rewards for staff that have gained qualifications;
- Treating the workforce with dignity and respect by valuing them professionally;
- Improve service user awareness and expectations of their rights. Increased awareness of direct payments and individual budgets, involvement in assessment and care planning, use of web tool technology, train service users to recruit PAs;
- More equity of provision and resources across the client groups – redistribution i.e. the equity bill: ironing out discrimination in health and social care services;
- Collect baseline data re effectiveness, local workforce and service user information, local labour market conditions;
- Better partnership working. Local authorities and providers develop better understanding of shared goals.

Deliberative Workshop 2 (19th November 2009)

PROVISION ACROSS BOUNDARIES – WORKFORCE IMPLICATIONS

Discussion Agenda

The discussion focussed on three different types of cross boundary worker.

WORKER 1 | Cross-Boundary (Generic) Support Workers

- What are the skills requirements for generic workers? What qualifications relate to these?
- What are the primary routes of accountability for generic workers?
- How does the generic worker role relate to different user/client/patient groups? What role in undertaking assessments by generic workers?

WORKER 2 | Frontline and Operational Management

- What are the skills requirements for managers of services with generic workers? What qualifications relate to the management role?
- What are the primary routes of accountability for those managing services with generic workers? Where they cross established boundaries, how can/should these be reconciled?
- How does the frontline or operational management role relate to different user/client/patient groups? What are the implications for assessment frameworks? Who assesses?

WORKER 3 | Strategic Management and Commissioning

- How well are/can strategic agendas be served by generic working? What provision is there for appropriate training and skills development? What '*buy-in*' is there from unions and professional bodies?
- What framework of accountability is or needs to be in place for '*mainstreaming*' new types of service and work practices? How do frameworks for strategic management relate to different user/client/patient groups?
- How can appropriate frameworks for service commissioning be reconciled with new service approaches?

Key outcomes of the discussion

- Valuing social care is key, including valuing the roles of management systems that make this possible;
- Value the workforce that we have by registering social care workers, therefore levelling playing field;
- Move sickness care back to health. Give people back a social care service;
- Ensure that the inspection process is robust and looks at things deep down, not just on the surface;
- Integration of social and healthcare is a productive way forward for the population, but needs better allocation of funding with a unified approach to registration and professional standards;
- Co-location of multi-disciplinary teams, health and social care joining funding, patients at the centre;
- Development of support worker, developing sharing of information between agencies. Improving information to service users, especially those without family support;
- Professional boundaries – accountability and governance e.g. trusted assessors;
- Spheres of influence is key – need to increase this for L/T support/home care workers;
- Independent sector providers rarely part of multi-disciplinary teams;
- Danger that generic workers have higher status that '*bread and butter*' workers;
- Generic workers have direct contact with other professionals – L/T core workers rarely do;
- Role of sheltered housing wardens. Delivery of social care. Disconnect in many areas currently;
- Suspicion that generic roles equal NHS shifting responsibility onto social services (without funding to follow);
- Different across service user groups – and different expectations of service users. Older people want to be looked after?

Care at Home: challenges, possibilities and implications for the workforce in Wales

Deliberative Workshop 3 (15th December 2009)

ROLE AND IMPACT OF FAMILIES AND COMMUNITIES – WORKFORCE IMPLICATIONS

Discussion Agenda

The discussion focussed on two specific issues:.

ISSUE 1 | Day-to-day relationships between care workers, service users, families and communities

- What are the issues for care workers in relation to service users, families and communities where no additional care is provided? How could these be overcome?
- How do care workers relate to service users, families and communities where informal care is provided free of charge in addition to their care? What challenges are there and how do we move past them?
- What are the principal considerations for care workers in relation to service users, families and communities when they are working alongside others who have been micro-commissioned (i.e. by a service user) as PAs to provide services? What are the solutions?

ISSUE 2 | Other occasions when care workers need to intervene between service users, families and communities

- What role is there for care workers as facilitators signposting service users, families, communities, informal carers to appropriate services? How can they be best supported in this role?
- How do care workers deal with situations of conflict, involving them or not? What skills and training do they have in place to deal with such circumstances?
- What are the ways in which care workers are currently '*assessing*' service users and? What impact does this have on service users, families, communities and other professionals? Is there scope for this role to be increased or decreased?

Key outcomes of the discussion

- Influence better care perspectives;
- To improve understanding, encourage more communication between all parties, especially commissioners;
- Raise carer awareness/ support/ signposting particularly in the independent sector;
- Start to raise profile of support workers and increase their value;
- Promote multi-disciplinary meetings. Suggest introducing / facilitating regular meetings between service users, families and support staff and LAs;
- Care plans need to truly show perspective of carers and real consideration needs to be made of how this can be embraced by the service delivered;
- Provider training. Also include training on carers' perspectives for care workers, social workers, commissioners etc. Invest in conflict training and problem solving. Review professional development needs of first line managers;
- Put pressure on commissioners of services to recognise that '*cheap and cheerful care*' is not the way the forward;
- Recognise the level of care provided by carers in the community. Therefore Carers are the largest contribution workforce;
- Ensure skills and issues discussed and check are specifically addressed for domiciliary care workers in the learning outcomes and assessment criteria for the qualifications currently being developed. Dissemination to UK partners for consideration in qualifications they are developing, at all levels and including managers. Also consider developing accredited training for some of the softer skills for care workers and first line managers;
- To improve care delivery suggest the Care Council learn more about fee management of domiciliary care and agree an appropriate range of qualifications for staff in a range of posts that recognises the immense skills and competencies needed to be part of a domiciliary care management team;
- Check quality of individual supervision and support;
- Practice guidance for care workers;

- Review process and involvements of provider feedback into care plans;
- Care workers should function within partnerships and not within hierarchies;
- Get rid of 15 minute visits! Important for lots of things but chiefly possibility of delivering good quality care in this time frame;
- Consider adding to contract and / or to contract monitoring process means of ascertaining what providers do to acknowledge care works opinions and views of service user circumstances, care plans, changing needs etc. And what they do with that information;
- Care Council further explore issue of ethical guidance. What, if anything, would be useful and add value without being a burden?

Deliberative Workshop 4 (21st January 2010)

OUTCOME-FOCUSED SERVICE PROVISION – WORKFORCE IMPLICATIONS

Discussion Agenda

1. **What are the expectations about what is to be delivered in OF services and how will this differ with standard models of care?**
   - How do workers, service users and families relate to a change of emphasis away from '*doing/caring*' towards '*facilitating/supporting*'?
   - How do you deal with services and workers that fail to empower service users despite the best intentions of all concerned?
2. **How do you ensure workers are adequately trained in using OF approaches to their tasks?**
   - How best should training be disseminated and what role should service users play in this?
   - How could the workforce be best engaged in ensuring outcomes are delivered?
3. **How might you be able to strike the balance between empowering service users and working to set visit times?**
   - What enablers would need to be in place to make this a reality?
4. **To what extent will the challenge of personalisation be met by a move to OF working?**
   - Are home care workers currently able to meet the potential demand for more OF and personalised services? What support do they need?
   - Does OF mean the same thing as person-focused?
5. **How should the workforce contribute to the measurement of outcomes?**
   - What data collection mechanisms would need to be put in place in order for this task to be undertaken effectively?
   - Is there a greater role for care workers in making such assessments?
6. **How do we ensure workers deliver outcomes people want rather than what professionals think they require? Is there a gap and if so how do we reconcile it?**

Key outcomes of the discussion

- Recognise different sets of outcomes, for service users, carers and their families, care worker, providers and commissiones;
- Interdependence more important than independence. Mutualism as a way forward for service provision;
- Implement training for carers;
- Recognise the importance of emotional and social roles. Important that care provided improves the service user experience and promotes their well-being. Service provision is not just about doing a task but recognising the impact that task has on the service users quality of life;
- Outcomes Focussed Service Provision pilot detailed key points of this model of service provision as: Allowing service users to assess and take risks within certain boundaries and providing organisational support for the care worker is a difficult balance to strike. Realise the significance of relationships and not viewing service user as an isolated unit. Acknowledging the roles and views of carers and family members. Regular reassessments which could include phone calls to the service users for feedback. Provider being more proactive in supporting the service user. Commissioners try to respond more quickly in an attempt to make service provision more fluid;

- Care worker training required for outcomes focussed service provision often involves revisiting skills they are already trained in but haven't utilised whilst delivering task orientated service delivery; refresher courses;
- There is a need for shared assessment process. Carer assessments should be weighted more in the assessment process and not just sit on the periphery. An extended assessment process makes for a better relationship with professionals, service users and carers. Communication between agencies is an '*invest to save*' need. Multi disciplinary meetings with communication in all directions are a must have. Value and trust one another professionally!;
- Need to remember that home care is not the only care service at home and that there are many enabling services;
- A need for commissioning from the '*bottom up*' starting from what users want themselves'. Service users driving change in commissioning processes, Commissioning a service rather than commissioning hours? Over commissioning of service as a risk averse practice – accountability issues;
- Need to value the people who put in the care: Encourage '*valuing the workforce strategies*'. Encourage more contact, more information sharing (in multiple directions). More skills and responsibility required from the care worker but no more pay?;
- Recognise the problem of changing approaches. Some people can feel devalued when being removed from the tasks they have been trained for. Sometimes tasks can be a '*comfort zone*' for staff who are scared of the emotional side of things and relationship development;
- Funding is an inhibitor to change. Assumption that outcomes focussed service provision will cost more but is there an evidence base for either argument?;
- Could shaving a ?%-?% off the health budget and investing in the community be a way forward? Many health problems are related to social determinants so investing in improving social determinants will reduce demands on health;
- CSSIW can assist with the changes by recognising that different specialities are required for different home care client groups;
- Tasks that lend themselves to outcome focussed working are maintenance, rehabilitation, prevention, motivation (for self care), and signposting;
- Need more partnership working between authorities, but problem for commissioners. A consortia approach might assist;
- Integration necessary between social care and health care;
- Be more imaginative re data collection – build into manager reviews or carry out on a scheduled basis;
- Could commissioners commission on outcomes rather than services? Quality measures, no matter how brilliant, will not weigh heavily enough against cost?;
- Duplicated form filling / data gathering by regulators and commissioners – can they not communicate to develop an information sharing system where providers can complete data once. Impact on resource saving for providers would be significant – standardised returns would release time and money for provider organisations;
- Political development required in the following areas. It is lacking central drive, competitive tendering is a barrier, make partnership working a reality, the thinking and language is right but all the bits need to come together; there is a lack of connectivity;
- With regard to commissioning standards. Will inspectors be consistent across the country re interpretation of outcomes measurements? 22 different processes, data collection and monitoring systems will not help;
- Some hopes expressed re outcomes for this research project were pan-Wales data collection, putting policy into practice, political drive, improvements to cross border working, staff fluidity, trust and dignity at a local level, coordinated civil servants, Assembly Government, cross border bodies (HIW, CSSIW, Care Council etc);
- Assembly Government setting of better frameworks would be acceptable in context of greater flexibility in delivery being facilitated.

APPENDIX 8 | FUNCTIONAL MAP OF CARE AT HOME IN WALES

Key Area

A. Develop understanding and insight about access to and provision of domiciliary care and support

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
AA. Commission research into domiciliary care and support			HI4 Commission, monitor and evaluate projects to advance knowledge and practice			Community Justice NOS
AB. Manage research into domiciliary care and support				CPC 303 Research and manage information		Commissioning, Procurement and Contracting NOS
			CPC 403 Enable understanding of the commissioning environment in your area of responsibility			Commissioning, Procurement and Contracting NOS
AC. Identify and evaluate people's needs and preferences in respect of domiciliary care and support			CPC 408 Research the needs of the local population for the provision of services			Commissioning, Procurement and Contracting NOS
AD. Identify and evaluate the provision of domiciliary care and support			CPC 416 Find out if the market can deliver services to meet priorities and outcomes			Commissioning, Procurement and Contracting NOS
AE. Identify and evaluate relevant theories and practice relating to domiciliary care and support			HI2 Develop and maintain a strategic overview of developments in knowledge and practice			Community Justice NOS
			HI3 Develop, implement and evaluate strategies to advance knowledge and practice			Community Justice NOS
AF. Analyse, interpret and synthesise research findings to inform policy and practice in domiciliary care and support				CPC 315 Contribute to establishing commissioning priorities and balancing demands on resources		Commissioning, Procurement and Contracting NOS
			CPC 429 Contribute to and influence policy and strategy development within and beyond your own organisation			Commissioning, Procurement and Contracting NOS
			HI5 Contribute to the evaluation and implementation of research and development outcomes			Community Justice NOS

Key Area

B. Develop, implement and evaluate policies and strategies for the provision of domiciliary care and support

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
BA. Develop policies and strategies for the provision of domiciliary care and support			CPC 410 Develop evidence based commissioning policies and strategies to improve outcomes			Commissioning, Procurement and Contracting NOS
		CPC 504 Negotiate the agreement and implementation of sustainable commissioning strategies for positive outcomes		CPC 303 Research and manage information		Commissioning, Procurement and Contracting NOS
		CPC 510 Develop a joint strategic needs assessment and delivery strategy				Commissioning, Procurement and Contracting NOS
			LMCE6 Contribute to the strategic policies of care services			Leadership and Management for Care Services NOS
BB. Communicate policies and strategies for the provision of domiciliary care and support						
BC. Implement policies and strategies for the provision of domiciliary care and support			CPC 409 Manage resources to meet priorities and demand			Commissioning, Procurement and Contracting NOS
BD. Evaluate policies and strategies for the provision of domiciliary care and support		CPC 512 Assess the impact of commissioning policy and strategy on improving outcomes for individuals, families and communities				Commissioning, Procurement and Contracting NOS

Key Area

C. Commission the provision of domiciliary care and support

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
CA. Develop structures, systems and models for the provision of domiciliary care and support			CPC 402 Promote effective arrangements for governance and organisational responsibility			Commissioning, Procurement and Contracting NOS
			CPC 405 Encourage innovative approaches to commissioning activities			Commissioning, Procurement and Contracting NOS
			CPC 406 Contribute to the development, maintenance and evaluation of systems to promote the rights, responsibilities, equality and diversity of individuals, families and communities			Commissioning, Procurement and Contracting NOS
			CPC 407 Ensure the engagement of individuals, families and communities in all commissioning activities			Commissioning, Procurement and Contracting NOS
			CPC 414 Initiate and implement change and improvement in services, provision and systems			Commissioning, Procurement and Contracting NOS
		CPC 502 Maintain governance of a person-centred commissioning culture that promotes inclusion, cohesion and regeneration				Commissioning, Procurement and Contracting NOS
		CPC 509 Enable your organisation to align or pool budgets with a partner				Commissioning, Procurement and Contracting NOS
CB. Develop the capacity of organisations and individuals to provide domiciliary care and support			CPC 417 Manage and develop the market to deliver your organisation's priorities and outcomes			Commissioning, Procurement and Contracting NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
			CPC 427 Plan, implement and manage the sharing of knowledge and good practice to inform innovation and improve delivery			Commissioning, Procurement and Contracting NOS
CC. Develop specifications for domiciliary care and support			CPC 415 Assess required outcomes and specify a sustainable supply of services			Commissioning, Procurement and Contracting NOS
CD. Contract with organisations to provide domiciliary care and support for people			HSC441 Invite tenders and award contracts			Health and Social Care NOS
			CPC 404 Negotiate effectively in order to promote positive outcomes			Commissioning, Procurement and Contracting NOS
			CPC 412 Work with partners to jointly commission services			Commissioning, Procurement and Contracting NOS
			CPC 419 Purchase goods and services to meet the continual development and the changing needs of the provision			Commissioning, Procurement and Contracting NOS
CE. Purchase domiciliary care and support for individuals			HSC443 Procure services for individuals			Health and Social Care NOS
CF. Support individuals to purchase their own domiciliary care and support				CPC 309 Support individuals, families and communities to commission their own services		Commissioning, Procurement and Contracting NOS
				CPC 314 Support the development of self-directed support		Commissioning, Procurement and Contracting NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
			CPC 418 Plan the development of self-directed support			Commissioning, Procurement and Contracting NOS
		CPC 511 Implement self-directed support in your organisation				Commissioning, Procurement and Contracting NOS
CG. Manage the performance of organisations providing domiciliary care and support			HSC442 Monitor and evaluate the quality, outcomes and cost-effectiveness of health, social and other care services			Health and Social Care NOS
				CPC 305 Work with providers to monitor and review performance against outcomes		Commissioning, Procurement and Contracting NOS
				CPC 306 Take action to secure contract compliance		Commissioning, Procurement and Contracting NOS
			CPC 421 Manage contracts to achieve outcomes			Commissioning, Procurement and Contracting NOS
			CPC 424 Improve contract performance			Commissioning, Procurement and Contracting NOS
			CPC 425 Implement quality assurance for your area of responsibility			Commissioning, Procurement and Contracting NOS
CH. Decommission services			CPC 420 De-commission services			Commissioning, Procurement and Contracting NOS
CI. Improve the effectiveness of commissioning			CPC 426 Evaluate and improve organisational performance for your area of responsibility			Commissioning, Procurement and Contracting NOS
			CPC 428 Assess the impact of commissioning activity on social, economic and environmental sustainability			Commissioning, Procurement and Contracting NOS

Key Area

D. Manage services to provide domiciliary care and support

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
DA. Manage the enterprise to provide domiciliary care and support	DA1 Develop, implement and review business and operational plans		BD4 Carry out a review of your business			Business Enterprise NOS
			BD5 Carry out your plans for the business			Business Enterprise NOS
			B1 Develop and implement operational plans for your area of responsibility			Management and Leadership NOS
		B3 Develop a strategic business plan for your organisation				Management and Leadership NOS
		B4 Put the strategic business plan into action				Management and Leadership NOS
			LMCE5 Plan operations and manage resources to meet current and future demands on the provision of care services			Leadership and Management for Care Services NOS
			LMCE7 Develop, implement and review business plans and planning for the provision of care services			Leadership and Management for Care Services NOS
	DA2 Manage physical resources		BL2 Choose a business premises			Business Enterprise NOS
			BS2 Monitor the quality and use of supplies and equipment in your business			Business Enterprise NOS
			E8 Manage physical resources			Management and Leadership NOS
			E9 Manage the environmental impact of your work			Management and Leadership NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
	DA3 Manage financial resources		MN1 Decide on your financial needs			Business Enterprise NOS
			MN2 Set and monitor financial targets for your business			Business Enterprise NOS
			MN7 Get finance for your business from informal or informal sources			Business Enterprise NOS
			MN5 Get customers to pay on time			Business Enterprise NOS
				E1 Manage a budget		Management and Leadership NOS
			E2 Manage finance for your area of responsibility			Management and Leadership NOS
			LMCE8 Manage finance for your area of responsibility			Leadership and Management for Care Services NOS
		E3 Obtain additional finance for the organisation				Management and Leadership NOS
	DA4 Manage supplies		BS1 Identify needs and suppliers for your business			Business Enterprise NOS
				E15 Procure supplies		Management and Leadership NOS
			E16 Select suppliers through a tendering process			Management and Leadership NOS
		E17 Outsource business processes				Management and Leadership NOS
	DA5 Provide governance for your organisation	B8 Ensure compliance with legal, regulatory, ethical and social requirements				Management and Leadership NOS
		B9 Develop the culture of your organisation				Management and Leadership NOS
			B11 Promote equality of opportunity, diversity and inclusion in your area of responsibility			Management and Leadership NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
		B12 Promote equality of opportunity, diversity and inclusion in your organisation				Management and Leadership NOS
	DA6 Develop, implement and review policies and strategies for managing volunteers		A1 Contribute to the development of strategy in an organisation that involves volunteers			Management of Volunteers NOS
		A2 Develop a volunteering policy				Management of Volunteers NOS
		A3 Develop structures, systems and procedures to support volunteering				Management of Volunteers NOS
		A4 Develop plans to meet strategic goals in an organisation that involves volunteers				Management of Volunteers NOS
		A5 Evaluate volunteers' contribution to strategic goals				Management of Volunteers NOS
			B1 Promote volunteering within your organisation			Management of Volunteers NOS
			B2 Promote volunteering to potential and actual volunteers			Management of Volunteers NOS
DB. Promote and sell domiciliary care and support services	DB1 Promote your organisation and its services		HSC437 Promote your organisation and its services to stakeholders			Health and Social Care NOS
			WB3 Plan how you will sell your products or services			Business Enterprise NOS
			WB4 Advertise your products or services			Business Enterprise NOS
			F16 Manage the development and marketing of products/services in your area of responsibility			Management and Leadership NOS
	DB2 Prepare and present proposals to deliver services		WB5 Sell your products or services			Business Enterprise NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
			WB9 Bid for work for your business			Business Enterprise NOS
			LMCE13 Market, cost and contract to ensure the viability of the provision of care services			Leadership and Management for Care Services NOS
	DB3 Negotiate and conclude contracts to deliver services		WB10 Make presentations about your business			Business Enterprise NOS
DC. Provide customer service	DC1 Deliver customer service		WB11 Decide how you will treat your business customers			Business Enterprise NOS
			WB12 Deliver a good service to customers			Business Enterprise NOS
			EE5 Build relationships to build your business			Business Enterprise NOS
	DC2 Manage customer service		F17 Manage the delivery of customer service in your area of responsibility			Management and Leadership NOS
DC. Develop, implement and review systems and processes to provide domiciliary care and support	DC1 Promote innovation					Management and Leadership NOS
			C2 Encourage innovation in your area or responsibility			Management and Leadership NOS
		C3 Encourage innovation in your organisation				Management and Leadership NOS
	DC2 Develop services		HSC45 Develop practices which promote choice, wellbeing and protection of all individuals			Health and Social Care NOS
			HSC429 Work with groups to promote individuals' growth, development and independence			Health and Social Care NOS
			HSC452 Contribute to the development, maintenance and evaluation of systems to promote the rights, responsibilities, equality and diversity of individuals			Health and Social Care NOS
			BD7 Improve the quality of products or services			Business Enterprise NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
	DC3 Manage services		LMCB2 Lead and manage provision of care services that promotes the well being of people			Health and Social Care NOS
			F3 Manage business processes			Management and Leadership NOS
	DC4 Review and improve services		BD6 Make changes to improve your business			Business Enterprise NOS
		C4 Lead change				Management and Leadership NOS
			C5 Plan change			Management and Leadership NOS
			C6 Implement change			Management and Leadership NOS
			LMCA2 Facilitate and manage change within care services through reflective, motivating and flexible leadership within your provision			Leadership and Management for Care Services NOS
			LMCE2 Identify, implement and evaluate systems, procedures and practice within care services that measure performance			Leadership and Management for Care Services NOS
DD. Manage workers to provide domiciliary care and support	DD1 Plan workforce requirements to provide domiciliary care and support		OP1 Review the skills your business needs			Business Enterprise NOS
			OP2 Plan what people your business needs			Business Enterprise NOS
		D4 Plan the workforce				Management and Leadership NOS
			WP1 Identify the purpose and scope of a workforce plan based on service needs			Workforce Planning NOS
			WP2 Identify and evaluate forces for change that may impact on the workforce			Workforce Planning NOS
				WP3 Contribute to preparing for workforce planning based on service needs		Workforce Planning NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
			WP4 Assess workforce demand			Workforce Planning NOS
			WP5 Assess workforce supply			Workforce Planning NOS
				WP6 Contribute to assessing workforce demand and supply		Workforce Planning NOS
			WP7 Develop a workforce plan			Workforce Planning NOS
			WP8 Implement and review a workforce plan			Workforce Planning NOS
				WP9 Contribute to developing and implementing a workforce plan		Workforce Planning NOS
	DD2 Recruit workers to provide domiciliary care and support		OP3 Recruit people			Business Enterprise NOS
			D3 Recruit, select and keep colleagues			Management and Leadership NOS
			LMCA3 Actively engage in the safe selection and recruitment of workers and their retention in care services			Leadership and Management for Care Services NOS
			C1 Manage the recruitment and placement of volunteers			Management of Volunteers NOS
			C2 Advertise for volunteers			Management of Volunteers NOS
			C3 Recruit and place volunteers			Management of Volunteers NOS
	DD3 Induct workers to the organisation and their work		OP5 Make sure people can do their work			Business Enterprise NOS
			C4 Manage the induction of volunteers			Management of Volunteers NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
			C5 Induct volunteers			Management of Volunteers NOS
	DD4 Support the development of workers' knowledge, skills and competence		HSC43 Take responsibility for the continuing professional development of self and others			Health and Social Care NOS
			YS2 Check your ability to run your business			Business Enterprise NOS
			D7 Provide learning opportunities for colleagues			Management and Leadership NOS
				D3 Support the development of volunteers' knowledge, skills and competence		Management of Volunteers NOS
				D5 Enable volunteers to learn in groups		Management of Volunteers NOS
	DD5 Lead teams of workers		HSC451 Lead teams to support a quality provision			Health and Social Care NOS
				B5 Provide leadership for your team		Management and Leadership NOS
			B6 Provide leadership in your area of responsibility			Management and Leadership NOS
		B7 Provide leadership for your organisation				Management and Leadership NOS
				D9 Build and manage teams		Management and Leadership NOS
				D10 Reduce and manage conflict in your team		Management and Leadership NOS
			E14 Support team and virtual working			Management and Leadership NOS
				D1 Plan, organise and monitor volunteering activities		Management of Volunteers NOS
				D2 Lead and motivate volunteers		Management of Volunteers NOS
			LMCA1 Manage and develop yourself and your workforce within care services			Leadership and Management for Care Services NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
			LMCA4 Manage a dispersed workforce to meet the needs and preferences of individuals at home			Leadership and Management for Care Services NOS
	DD6 Allocate work to workers		HSC446 Manage a dispersed workforce to meet the needs and preferences of individuals at home			Health and Social Care NOS
			YS3 Improve your business skills			Business Enterprise NOS
				D5 Allocate and check work in your team		Management and Leadership NOS
			D6 Allocate and monitor the progress and quality of work in your area of responsibility			Management and Leadership NOS
			LMCA5 Allocate and monitor the progress and quality of work in your area of responsibility			Leadership and Management for Care Services NOS
	DD7 Provide professional supervision to workers		LMCE10 Ensure policies, procedures and practice for the conduct of workers within care services are adhered to			Leadership and Management for Care Services NOS
	DD8 Provide coaching support to workers		D13 Support individuals to improve, develop and maintain their performance			Management and Leadership NOS
				D4 Provide one-to-one support to help volunteers develop		Management of Volunteers NOS
	DD9 Support workers who are having problems with their work			HSC3110 Support colleagues to relate to individuals		Health and Social Care NOS
			OP5 Make sure people in your business can do their work			Business Enterprise NOS
			OP7 Deal with workplace problems or disputes			Business Enterprise NOS
			D8 Help team members address problems affecting their performance			Management and Leadership NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
			D14 Initiate and follow disciplinary procedures			Management and Leadership NOS
			D15 Initiate and follow grievance procedures			Management and Leadership NOS
				D8 Help address problems affecting volunteers		Management of Volunteers NOS
	DD10 Handle relocation and redundancy situations		OP8 Change job roles and handle redundancy			Business Enterprise NOS
			D16 Manage redundancies in your area of responsibility			Management and Leadership NOS
	DD11 Manage records of workers			D6 Maintain records of volunteers		Management of Volunteers NOS
				D7 Manage volunteers' expenses		Management of Volunteers NOS
DE. Manage risks involved in providing domiciliary care and support	DE1 Manage business risks	B10 Manage risk				Management and Leadership NOS
	DE2 Manage health and safety risks		HSC42 Contribute to the development and maintenance of healthy and safe working practices in the working environment			Health and Social Care NOS
				LG3 Develop procedures to control risks to health and safety		Business Enterprise NOS
				E5 Identify assess and control health and safety risks		Management and Leadership NOS
			E6 Ensure health and safety requirements are met in your area of responsibility			Management and Leadership NOS
		E7 Ensure an effective organisational approach to health and safety				Management and Leadership NOS
			LMCE4 Lead and manage provision of care services that promotes opportunities, identifies constraints and manages risk			Leadership and Management for Care Services NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
DF. Manage contracts to provide domiciliary care and support	DF1 Manage individual projects		F1 Manage projects			Management and Leadership NOS
			LMCE11 Manage a project			Leadership and Management for Care Services NOS
	DF2 Manage a programme of projects	F2 Manage a programme of complementary projects				Management and Leadership NOS
		LMCE12 Manage a programme of complementary projects				Leadership and Management for Care Services NOS
DG. Assure the quality of domiciliary care and support	DG1 Promote and manage a quality provision		LMCE3 Monitor and manage the quality of the provision of care services			Leadership and Management for Care Services NOS
	DG2 Ensure individuals and groups are supported appropriately when experiencing significant life events and transitions					
	DG3 Manage quality systems		F13 Manage quality systems			Management and Leadership NOS
	DG4 Prepare for and participate in quality audits			F14 Prepare for and participate in quality audits		Management and Leadership NOS
	DG5 Carry out quality audits			F15 Carry out quality audits		Management and Leadership NOS
DH. Manage information relating to domiciliary care and support	DH1 Receive and pass on messages and information				HSC242 Receive and pass on messages and information	Health and Social Care NOS
	DH2 Receive, analyse, process, use and store information			HSC3115 Receive, analyse, process, use and store information		Health and Social Care NOS
	DH3 Use and develop methods and systems to communicate and report		HSC41 Use and develop methods and systems to communicate and report			Health and Social Care NOS
	DH4 Maintain and manage records and reports		HSC434 Maintain and manage records and reports			Health and Social Care NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
	DH5 Promote effective communication and information sharing			CPC 311 Promote effective communication and information sharing		Commissioning, Procurement and Contracting NOS
			LMCE1 Lead and manage effective communication that promotes positive outcomes for people within care services			Leadership and Management for Care Services NOS
	DH6 Lead meetings		D11 Lead meetings			Management and Leadership NOS
	DH7 Participate in meetings			D12 Participate in meetings		Management and Leadership NOS
	DH8 Take effective decisions		E10 Take effective decisions			Management and Leadership NOS
	DH9 Communicate information and knowledge		E11 Communicate information and knowledge			Management and Leadership NOS
	DH10 Manage knowledge in your area of responsibility		E12 Manage knowledge in your area of responsibility			Management and Leadership NOS
	DH11 Promote knowledge management in your organisation	E13 Promote knowledge management in your organisation				Management and Leadership NOS
DI. Work collaboratively	DI1 Work collaboratively with staff, volunteers and colleagues		CPC 401 Develop effective working relationships			Commissioning, Procurement and Contracting NOS
		D2 Develop productive working relationships with colleagues and stakeholders				Management and Leadership NOS
			E3 Develop productive working relationships with volunteers and other stakeholders			Management of Volunteers NOS
			E4 Promote productive working relationships between volunteers and other stakeholders			Management of Volunteers NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
			LMCD3 Lead and manage inter-professional teams within care services			Leadership and Management for Care Services NOS
	DI2 Work collaboratively with other agencies		HSC433 Develop joint working agreements and practices and review their effectiveness			Health and Social Care NOS
		CPC 501 Develop strategic partnerships and alliances for commissioning				Commissioning, Procurement and Contracting NOS
		D17 Build and sustain collaborative relationships				Management and Leadership NOS
		E5 Develop and maintain partnership working to support your volunteering strategy				Management of Volunteers NOS
			LMCD1 Lead and manage work for care services with networks, communities, other professionals and organisations			Leadership and Management for Care Services NOS
			LMCD2 Manage workers within care services who are based in external multi-disciplinary teams			Leadership and Management for Care Services NOS

Key Area

E. Enable individuals to access domiciliary care and support

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
EA. Provide information about domiciliary care and support						
EB. Support individuals to access domicilairy care and support			HSC330 Support individuals to access and use services and facilities			Health and Social Care NOS
EC. Manage requests for domiciliary care and support		HSC413 Manage requests for health and care services				Health and Social Care NOS

Key Area

F. Assess individuals' needs for, and rights to, domiciliary care and support

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
FA. Assess individuals' needs and preferences for domiciliary care and support		HSC414 Assess individual needs and preferences				Health and Social Care NOS
			HSC339 Carry out assessment to identify and prioritise needs			Health and Social Care NOS
		LMCB5 Manage and evaluate systems, procedures and practices for assessments, plans and reviews within care services				Leadership and Management for Care Services NOS
		HSC427 Assess the needs of carers and families				Health and Social Care NOS
FB. Assess individuals' right to financial contributions to the cost of domiciliary care and support						
FC. Support individuals to provide information to obtain financial contributions to the cost of domiciliary care and support						
FD. Review individuals' needs and preferences for domiciliary care and support						

Key Area

G. Assess and manage risks involved in providing domiciliary care and support to individuals

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
GA. Assess the risks involved in providing domiciliary care and support to individuals			HSC3117 Conduct a health and safety risk assessment of a workplace			Health and Social Care NOS
		LMCC1 Develop and maintain systems, procedures and practice of care services to manage risks and comply with health and safety requirements within your provision				Leadership and Management for Care Services NOS
GB. Assess the risks of harm and abuse to individuals				HSC240 Contribute to the identification of the risk of danger to individuals and others		Health and Social Care NOS
GC. Develop and implement plans to manage isks involved in providing domiciliary care and support to individuals		HSC450 Develop risk management plans to support individuals' independence and daily living in their own home				Health and Social Care NOS
		LMCC2 Develop risk management plans to support individual's independence and daily living within their home				Health and Social Care NOS
GD. Support individuals where abuse has been disclosed		HSC431 Support individuals where abuse has been disclosed				Health and Social Care NOS

Key Area

H. Specify, plan and review the provision of domiciliary care and support to individuals

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
HA. Produce, evaluate and amend service delivery plans to meet individuals' needs and preferences			HSC328 Contribute to care planning and review			
			HSC329 Contribute to planning, monitoring and reviewing the delivery of service for individuals			Health and Social Care NOS
		HSC416 Develop, implement and review care or support plans with individuals				Health and Social Care NOS
		HSC415 Produce, evaluate and amend service delivery plans to meet individual needs and preferences				Health and Social Care NOS
		HSC428 Assess, implement and review programmes of support for carers and families				Health and Social Care NOS

Key Area

I. Provide specific planned domiciliary care and support to individuals

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
IA. Provide domiciliary care and support in line with legal, professional and organisational requirements	IA1 Promote equality, diversity, rights and responsibilities				HSC234 Ensure your own actions support the equality, diversity, rights and responsibilities of individuals	Health and Social Care NOS
				HSC3111 Promote the equality, diversity, rights and responsibilities of individuals		Health and Social Care NOS
			LMCB1 Lead and manage provision of care services that respects, protects and promotes the rights and responsibilities of people			Leadership and Management for Care Services NOS
	IA2 Promote individuals' choice, well-being and protection				HSC24 Ensure your own actions support the care, protection and well-being of individuals	Health and Social Care NOS
				HSC35 Promote choice, well-being and the protection of all individuals		Health and Social Care NOS
				HSC335 Contribute to the protection of individuals from harm and abuse		Health and Social Care NOS
					HSC240 Contribute to the identification of the risk of danger to individuals and others	Health and Social Care NOS
			HSC430 Support the protection of individuals, key people and others			Health and Social Care NOS
			LMCB2 Lead and manage provision of care services that promotes the well being of people			Leadership and Management for Care Services NOS
			LMCB3 Manage provision of care services that deals effectively with transitions and significant life events			Leadership and Management for Care Services NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
	IA3 Maintain effective communication with and about individuals				HSC21 Communicate with, and complete records for individuals	Health and Social Care NOS
				HSC31 Promote effective communication for and about individuals		Health and Social Care NOS
	IA5 Manage your own time and workload				HSC244 Manage and organise time and activities to support individuals in the community	Health and Social Care NOS
	IA5 Continuously develop your own professional practice				HSC23 Develop your knowledge and practice	Health and Social Care NOS
				HSC33 Reflect on and develop your practice		Health and Social Care NOS
IB. Carry out and provide feedback on activities specified in domiciliary care plan for individuals					HSC25 Carry out and provide feedback on specific plan of care activities	Health and Social Care NOS
IC. Contribute to health, safety and security in individuals' homes	IC1 Contribute to health and safety of yourself and others				HSC22 Support the health and safety of yourself and individuals	Health and Social Care NOS
				HSC32 Promote, monitor and maintain health, safety and security in the working environment		Health and Social Care NOS
					HSC232 Protect yourself from risk of violence at work	Health and Social Care NOS
	IC2 Contribute to the security of individuals' homes				HSC229 Gain access to, and ensure individuals' homes are secure	Health and Social Care NOS
ID. Establish and sustain relationships with individuals	ID1 Relate to individuals under normal circumstances				HSC233 Relate to, and interact with individuals	Health and Social Care NOS
				HSC331 Support individuals to develop and maintain social networks and relationships		Health and Social Care NOS
	ID2 Support the emotional and identity needs of individuals			HSC332 Support the emotional and identity needs of individuals		Health and Social Care NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
					HSC226 Support individuals who are distressed	Health and Social Care NOS
IE. Support individuals with their daily living needs	IE1 Support individuals with their daily domestic and personal requirments				HSC27 Support individuals in their daily living	Health and Social Care NOS
				HSC343 Support individuals to live at home		Health and Social Care NOS
					HSC29 Support individuals to meet their domestic and personal needs	Health and Social Care NOS
	IE2 Support individuals to maintain a clean and safe living environment				HSC246 Maintain and clean and safe environment	Health and Social Care NOS
	IE3 Support individuals access and use information				HSC26 Support individuals to access and use information	Health and Social Care NOS
	IE4 Support individuals to retain, regain and develop skills to manage their lives and environment			HSC344 Support individuals to retain, regain and develop the skills to manage their lives and environment		Health and Social Care NOS
	IE5 Support individuals to exercise and maintain their mobility				HSC215 Help individuals to keep mobile	Health and Social Care NOS
	IE6 Support individuals to find their way around environments				HSC235 Enable individuals to negotiate specific environments	Health and Social Care NOS
				HSC372 Plan and implement programmes to enable individuals to find their way around familiar environments		Health and Social Care NOS
				HSC373 Plan and implement programmes to enable individuals to find their way around unfamiliar environments		Health and Social Care NOS
	IE7 Support individuals to move and settle into new living environments			HSC382 Support individuals to prepare for, adapt to and manage change		
				HSC383 Prepare and support individuals to move and settle in new living environments		Health and Social Care NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
	IE8 Support individuals to make journeys				HSC28 Support individuals to make journeys	Health and Social Care NOS
	IE9 Support the provision and maintenance of equipment				HSC243 Monitor, handle and maintain materials and equipment	Health and Social Care NOS
IF. Support individuals to eat and drink	IF1 Prepare and provide food and drink for individuals				HSC213 Provide healthier food and drink for individuals	Health and Social Care NOS
	IF2 Help individuals eat and drink				HSC214 Help individuals to eat and drink	Health and Social Care NOS
	IF3 Support individuals to take nutrition and fluid other than by mouth			CHS17 Carry out extended feeding techniques to ensure individuals nutritional and fluid intake		Clinical Health Skills NOS
IG. Support individuals with their personal care needs	IG1 Support individuals with a range of personal care needs				HSC218 Support individuals with their personal care needs	Health and Social Care NOS
	IG2 Contribute to moving, handling and positioning individuals				HSC 223 Contribute to moving and handling of individuals	Health and Social Care NOS
				HSC360 Move and position individuals		Health and Social Care NOS
	IG2 Help address the physical comfort needs of individuals				HSC216 Help address the physical comfort needs of individuals	Health and Social Care NOS
	IG3 Undertake agreed pressure area care				HSC217 Undertake agreed pressure area care	Health and Social Care NOS
	IG4 Support individuals to manage continence				HSC219 Support individuals to manage continence	Health and Social Care NOS
	IG5 Provide general foot care for individuals				HSC220 Maintain the feet of individuals who have been assessed as requiring general foot care	Health and Social Care NOS
	IG6 Support individuals to maintain and use appliances and prostheses					
IH. Support individuals to undertake specific activities	IH1 Support individuals to access and participate in recreational activities				HSC210 Support individuals to access and participate in recreational activities	Health and Social Care NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
	IH2 Support individuals to access and participate in development activities				HSC211 Support individuals to take part in development activities	Health and Social Care NOS
				HSC348 Help individuals to access learning, training and development opportunities		Health and Social Care NOS
				HSC351 Plan, agree and implement development activities to meet individual needs		Health and Social Care NOS
	IH3 Support individuals during therapy sessions				HSC212 Support individuals during therapy sessions	Health and Social Care NOS
				HSC352 Support individuals to continue therapies		Health and Social Care NOS
	IH4 Support the spiritual wellbeing of individuals			HSC350 Recognise, respect and support the spiritual wellbeing of individuals		Health and Social Care NOS
IJ. Support individuals to meet their healthcare needs	IJ1 Support individuals to maintain their own health and wellbeing				HSC225 Support individuals to undertake and monitor their own healthcare	Health and Social Care NOS
				HSC3112 Support individuals to identify and promote their own health and wellbeing		Health and Social Care NOS
	IJ2 Take physiological measurements of individuals			HSC361 Prepare for, and undertake physiological measurements		Health and Social Care NOS
	IJ3 Assist in the administration of medication				HSC221 Assist in the administration of medication	Health and Social Care NOS
	IJ4 Support individuals prior to, during and after clinical procedures				HSC222 Support individuals prior to, during and after clinical procedures	Health and Social Care NOS
	IJ5 Observe, monitor and record the condition of individuals				HSC224 Observe, monitor and record the condition of individuals	Health and Social Care NOS
	IJ6 Support the care and maintenance of simple dressings and wounds			CHS12 Undertake treatments and dressings related to the care of lesions and wounds		Clinical Health Skills NOS
	IJ7 Respond to individuals requiring emergency medical assistance			HSC374 Provide first aid to an individual needing emergency assistance		Health and Social Care NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
	IJ8 Provide basic life support			CHS36 Provide basic life support		Clinical Health Skills NOS
	IJ10 Help individuals to use oxygen safely and effectively			CHS72 Help individuals to use oxygen safely and effectively		Clinical Health Skills NOS
	IJ8 Support individuals to maintain a clear airway					
	IJ9 Support individuals to undertake dialysis therapy at home			HSC377 Encourage and support individuals undergoing dialysis therapy at home		Health and Social Care NOS
IK. Support individuals who misuse intoxicating substances	IK1 Recognise indications of substance misuse and refer individuals to specialists			HSC362 Recognise indications of substance misuse and refer individuals to specialists		Health and Social Care NOS
	IK2 Support individuals who are substance users			HSC379 Support individuals who are substance users		Health and Social Care NOS
	IK3 Assess and act upon immediate risk of danger to substance users			HSC342 Assess and act upon immediate risk of danger to substance users		Health and Social Care NOS
IL. Support individuals to address their challenging behaviour	IL1 Provide frameworks to help individuals manage challenging behaviour			HSC337 Provide frameworks to help individuals manage challenging behaviour		Health and Social Care NOS
			LMCB8 Lead and manage provision of care services that promotes positive behaviour			Leadership and Management for Care Services NOS
	IL2 Enable people with mental health problems to develop coping strategies			HSC396 Enable people with mental health problems to develop coping strategies		Health and Social Care NOS
	IL3 Reinforce positive behavioural goals during relationships with individuals			HSC397 Reinforce positive behavioural goals during relationships with individuals		Health and Social Care NOS
	IL4 Contribute to the prevention and management of abusive and aggressive behaviour			HSC336 Contribute to the prevention and management of abusive and aggressive behaviour		Health and Social Care NOS
IM. Support individuals to communicate	IM1 Support individuals with specific communication needs			HSC369 Support individuals with specific communication needs		Health and Social Care NOS
	IM2 Support individuals to communicate using technology			HSC370 Support individuals to communicate using technology		Health and Social Care NOS
	IM3 Support individuals to communicate using interpreting and translation services			HSC371 Support individuals to communicate using interpreting and translation services		Health and Social Care NOS

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
IN. Support individuals through advocacy	IN1 Support individuals to represent their own needs and wishes at decision making forums			HSC366 Support individuals to represent their own needs and wishes at decision making forums		Health and Social Care NOS
	IN2 Help individuals identify and access independent representation and advocacy			HSC367 Help individuals identify and access independent representation and advocacy		Health and Social Care NOS
	IN3 Present individuals' needs and preferences			HSC368 Present individuals' needs and preferences		Health and Social Care NOS
			HSC410 Advocate with, and on behalf of, individuals, families, carers, groups and communities			Health and Social Care NOS
IO. Support individuals to manage financial matters	IO1 Support individuals to manage their financial affairs			HSC345 Support individuals to manage their financial affairs		Health and Social Care NOS
	IO2 Support individuals to make direct payments			HSC346 Support individuals to manage direct payments		Health and Social Care NOS
	IO3 Help individuals to access employment			HSC347 Help individuals to access employment		Health and Social Care NOS
IP. Support individuals to manage housing matters				HSC349 Enable individuals to access housing and accommodation		Health and Social Care NOS
IQ. Support individuals through dying, death and bereavement	IQ1 Support individuals through the process of dying			HSC385 Support individuals through the end of life process		Health and Social Care NOS
	IQ2 Contribute to the care of a deceased person				HSC239 Contribute to the care of a deceased person	Health and Social Care NOS
	IQ3 Support individuals through bereavement			HSC384 Support individuals through bereavement		Health and Social Care NOS
IR. Work with other workers and agencies	IR1 Work as a member of a team			HSC3100 Participate in interdisciplinary team working to support individuals		Health and Social Care NOS
					HSC241 Contribute to the effectiveness of teams	Health and Social Care NOS
					HSC228 Contribute to effective group care	Health and Social Care NOS
	IR2 Assist in the transfer of individuals between agencies and services			HSC386 Assist in the transfer of individuals between agencies and services		Health and Social Care NOS

Key Area

J Provide support to carers and family members

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
JA Relate to carers and family members				HSC388 Relate to families, parents and carers		Health and Social Care NOS
				HSC389 Work with carers, families and key people to maintain contact with individuals		Health and Social Care NOS
JB Support carers in the caring role					HSC227 Contribute to working with carers in the caring role	Health and Social Care NOS
				HSC387 Work in collaboration with carers in the caring role		Health and Social Care NOS
			LMCB4 Manage provision of care services that supports parents, families, carers and significant others to achieve positive outcomes			Leadership and Management for Care Services NOS
				HSC392 Work withn families, carers and individuals during times of crisis		Health and Social Care NOS
JC Provide services to carers and famililies affected by individuals' substance use				HSC391 Provide services to those affected by someone else's substance use		Health and Social Care NOS
JD Enable carers and families to address issues with individuals' behaviour			HSC432 Enable families to address issues with individuals' behaviour			Health and Social Care NOS
JE Provide respite for carers						

Key Area

K. Independently inspect domiciliary care and support services

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
KA. Develop, implement and review inspection policies and strategies		YA1 Develop a strategy for inspections or reviews				Inspection NOS
KB. Carry out inspections of domiciliary care and support services						
			YA2 Prepare a programme of inspection or review			Inspection NOS
				YA3 Plan and initiate an inspection or review		Inspection NOS
				YB1 Conduct an inspection or review		Inspection NOS
				YB2 Report and follow-up outcomes of inspections or reviews		Inspection NOS
KC. Handle critical incidents, concerns and complaints regarding domiciliary care and support services			YB3 Respond to critical incidents, concerns or complaints			Inspection NOS
KD. Administer registration of domiciliary care and support services			YB4 Evaluate and process applications for registration			Inspection NOS
KE. Support improvements in the provision of domiciliary care and support services			YC1 Enable improvements in organisational performance			Inspection NOS

Key Area

L. Resolve problems regarding the provision of domiciliary care and support services

Functional Area	Function	Relevant National Occupational Standards (Level)				NOS Suite
		5	4	3	2	
LA. Handle complaints regarding the provision of domiciliary care and support services		YA1 Develop a strategy for inspections or reviews		HH1 Obtain details from complainants and agree how to progress cases of complaint		Caseworkers NOS
				HH2 Progress and monitor cases of complaint		Caseworkers NOS
				HH3 Progress applications to cease the progression of complaints		Caseworkers NOS
				HH4 Contribute to developing and maintaining positive caller relationships		Caseworkers NOS
				HH5 Process complaints involving informal resolution		Caseworkers NOS
			HH6 Process appeals against decisions made regarding complaints			Caseworkers NOS
			LMCE9 Manage procedures within care services for making, responding to and learning from comments and complaints within your provision			Leadership and Management for Care Services NOS
			LA12 Manage legal advice			Legal Advice NOS
				LA12 Manage legal advice		Legal Advice NOS
				LA50 Welfare Rights Legal Advice and Casework		Legal Advice NOS

APPENDIX 9 | DEVELOPMENT OF THE GENERIC WORKER IN HEALTH AND SOCIAL CARE IN WALES

Who?	What?	Why? i.e. rationale given	Role Specified
Gwent Frailty Project (Aneurin Bevan LHB; Blaenau Gwent, Caerphilly, Newport, Torfaen & Monmouthshire LAs)	Programme called 'Happily Independent' – looking to create an integrated health and social care model of care that is community based. Includes creation of Support & Wellbeing Workers	■ Need for strategic change toward whole system management of more than just one part of the care process. ■ Existing health & social care provision under severe strain - economic climate. ■ Tackle inequalities and inequities in provision. ■ Tackle examples of poor User experiences. ■ Generic 'Support & Well being Worker' – response to users' requests for consistency in relationships with those who support	■ Build therapeutic relationship. ■ Think beyond task in hand & signpost. ■ Move towards outcome focus. ■ Work across teams & move through the system with the individual -continuity. ■ Ability to interchange between rapid access & longer term access. ■ Support carer, personal care, health tasks, advocate, co-ordination role, reablement work. Knowing boundaries. ■ Soft skills – negotiating with families, motivating, handing control to user. Not just task focused. ■ Phase 1 predominantly crisis intervention and contact for short time after. ■ May work in care homes. ■ Change agent. ■ See draft skill set (when available)
Powys LHB	Powys healthcare community have set up a task and finish group to identify appropriate support worker roles within the multi-disciplinary and multi-agency team. This work has been instigated to meet the needs of patients with chronic conditions in the community.		
Carmarthenshire	Planning a small pilot scheme to introduce generic workers into one area of the County early in 2010. Phase 2 will be the roll out to other parts of the County.	■ Improve outcomes for citizens - support independence. ■ Improve and streamline things that waste time and duplicate effort & visits. ■ Free up professional time. ■ Create capacity for more people to receive a service. ■ Increase staff confidence and job satisfaction. ■ Encourage young people to consider H&SC as a career pathway. ■ Prevent outward migration. ■ Reduce travel costs, paid travel time & carbon footprint. ■ Workforce able to function across 24 hrs. ■ Economic and regeneration agendas. ■ Support Welsh language workforce locally.	Currently working on a list of tasks for generic workers. Likely to include tasks such as wound dressings, cream application &eye drops.

Who?	What?	Why? i.e. rationale given	Role Specified
North Wales Community of Practice Betsi Cadwaladr LHB, 6 NW LAs & NLIAH	Undertaken analysis of the Health &Social Care support worker roles in Flintshire & Wrexham, Conwy & Denbighshire, Gwynedd & Anglesey. Project manager being considered across NW (NHS funded post). Proposed Project T&F group – to develop common core JD across NW, agreed title, pay , training. CHC monies giving impetus.	■ Work smarter in financial constraints. ■ Meet changing needs - services in right place. ■ Flexible and sustainable workforce. Career structures. ■ Strategic drivers - context of chronic conditions model	Agreeing role definition is part of project manager remit, also identify skills and competences.
Denbighshire	Health & Social Care Support Workers – in preparation for co-location of teams. Role piloted in Intermediate Care response services. Maximum of 6 weeks. H&SC workers employed in DCC home care service. SLA with LHB.	■ Revenue savings ■ Reduce duplication. Continuity of care. ■ Promote independence. ■ More support for carers. ■ Flexible workforce. ■ Strategy – Chronic Conditions services.	Competencies and role under discussion – but includes nursing, therapy and social care tasks. Adaptable roles based on delegation. Work will be audited to ensure balance of health and social care tasks. 5 core elements of the role: early ident. of need for further assessment; signposting and health promotion; enablement & reablement; social care including personal care
Cwm Taf LHB Chronic Conditions Management	Plan to develop a generic role working between health and social care. Targeting the CCM agenda/ service.	Project is in early planning stage. LHB is about to embark on an audit to assess activity and quantify the scale of service delivery e.g duplication and also identify gaps.	

APPENDIX 10 | ANALYSIS OF CROSS BOUNDARY SUPPORT WORKER PERSON SPECIFICATIONS AND JOB PROFILES

In order to illustrate how role profiles might be used as part of registration of the care at home workforce, a role profile for a support worker has been developed, drawing on job descriptions and person specifications submitted as evidence to this project.

The role profile comprises:

- Generic National Occupational Standards, which all workers registered in this '*class*' would be expected to meet;
- Role-specific National Occupational Standards, which workers may or not be expected to meet, depending on their role and the needs and preferences of their service users (NB a worker may need one set of NOS for service user A and a different set of NOS for service user B);
- Possible New National Occupational Standards, covering new functions which will become increasingly important in certain contexts.

NOS highlighted in bold are those which the research indicates are areas where improvements in the competence and consistency of the care at home workforce would significantly enhance the experience for service users and carers.

CORE NATIONAL OCCUPATIONAL STANDARDS

HSC21 Communicate with, and complete records for individuals

HSC22 Support the health and safety of yourself and individuals

HSC23 Develop your knowledge and practice

HSC24 Ensure your own actions support the care, protection and well-being of individuals

HSC25 Carry out and provide feedback on specific plan of care activities

HSC233 Relate to, and interact with individuals

HSC234 Ensure your own actions support the equality, diversity, rights and responsibilities of individuals

HSC244 Manage and organise time and activities to support individuals in the community

HSC27 Support individuals in their daily living

ROLE-SPECIFIC NATIONAL OCCUPATIONAL STANDARDS

HSC210 Support individuals to access and participate in recreational activities

HSC211 Support individuals to take part in development activities

HSC212 Support individuals during therapy sessions

HSC213 Provide healthier food and drink for individuals

HSC214 Help individuals to eat and drink

HSC215 Help individuals to keep mobile

HSC216 Help address the physical comfort needs of individuals

HSC217 Undertake agreed pressure area care

HSC218 Support individuals with their personal care needs

HSC219 Support individuals to manage continence

HSC220 Maintain the feet of individuals who have been assessed as requiring general foot care

HSC221 Assist in the administration of medication

HSC223 Contribute to moving and handling of individuals

HSC224 Observe, monitor and record the condition of individuals

HSC225 Support individuals to undertake and monitor their own healthcare

HSC226 Support individuals who are distressed

HSC227 Contribute to working with carers in the caring role

HSC228 Contribute to effective group care

HSC229 Gain access to, and ensure individuals' homes are secure

HSC232 Protect yourself from risk of violence at work

HSC235 Enable individuals to negotiate specific environments

HSC239 Contribute to the care of a deceased person

HSC240 Contribute to the identification of the risk of danger to individuals and others

HSC241 Contribute to the effectiveness of teams

HSC243 Monitor, handle and maintain materials and equipment

HSC246 Maintain a clean and safe environment

HSC26 Support individuals to access and use information

HSC28 Support individuals to make journeys

HSC29 Support individuals to meet their domestic and personal needs

POSSIBLE NEW NATIONAL OCCUPATIONAL STANDARDS

Contribute to assessing, planning and monitoring and reviewing support for individuals in their homes

Support individuals to work towards targets for improving their health and wellbeing

Manage your relationship as an employee of the service user

APPENDIX 11 | CROSS REFERENCE BETWEEN FINAL REPORT RECOMMENDATIONS AND 'YOUR VIEW' SOLUTIONS

Note that the points below are those of the consultees, not of the researchers.

Most are paraphrased so that meanings are retained. Other changes have recast the assertions in the third as opposed to the first person.

They represent a valuable source of thought and opinion which has informed the research and, in most cases, is reflected in the five Key Recommendations and sub-recommendations. Certainly they serve to endorse a unanimous view that there is an urgent need for reform in the manner of delivery of care at home services. There is, therefore, an endorsement of ways of working that are more person- (user) focused; and move away from narrowly rigid and/or task driven approaches. Some of the relevant NOS are indicated as responding to the points.

Linking to Recommendation 1

A1 There needs to be a greater recognition of the value of care at home workers. This should be reflected in a higher pay package and better terms and conditions. [B9 Develop the culture of your organisation]

A2 Part of the image problem with being '*only a care worker*' is about recognition. Professional registration will help. Registration might also mean that the Code of Practice issued by the Care Council could be more readily enforced.

A3 There needs to be clear career development pathways for care at home workers - from the lowest pay grades upwards.

A4 Care at home workers need to be supported both in and out of the workplace to gain competence-based qualifications, whether the current National Vocational Qualifications (NVQs) Level 2/3 or their replacements on the Qualifications and Credit Framework (QCF). These should include provision for role-specific competences and new competences covering newly emerging functions.

A6 Better management and supervision of care at home workers is necessary. [HSC446 Manage a dispersed workforce to meet the needs and preferences of individuals at home; HSC25 Carry out and provide feedback on specific plan of care activities]

A8 Outcomes of the work undertaken by care at home workers should be identified, measured and discussed. [B9 Develop the culture of your organisation; CPC 426 Evaluate and improve organisational performance for your area of responsibility]

A10 It should be possible for local authorities to provide a preferred list of (quality assured) training providers.

A13 Care Council should promote a series of existing qualifications (or create new ones) in order to enhance knowledge and skills for those who manage the care at home workforce.

A14 Joint training and joint accreditation (primarily across the health and social care boundary) should be maximised. The QCF offers such an opportunity.

A16 In providing training programmes it is essential to challenge the mindset of care workers and ensure they see beyond just doing a task. They need to realise why they are doing that task, and what carrying out that task means. [HSC25 Carry out and provide feedback on specific plan of care activities]

B1 New work-based qualifications for commissioners (on commissioning, procurement and contracting) need to become part of their mandatory training. [NOS for Commissioning, Procurement and Contracting]

B7 Better baseline data is needed regarding the numbers, training and knowledge base of the care at home workforce to assist in service planning. Registration will help in this process. [WP5 Assess workforce supply]

C2 The isolation of personal assistants can be reduced by their inclusion in needs assessment and training by the local authority. They should be regarded as employees/workers for the purposes of safeguarding, registration etc. [D7 Provide learning opportunities for colleagues]

C10 There is a key role for front line managers to ensure the competence of care workers to deliver culturally sensitive care. [HSC234 Ensure your own actions support the equality, diversity, rights and responsibilities of individuals; HSC3111 Promote the equality, diversity, rights and responsibilities of individuals; LMCB1 Lead and manage provision of care services that respects, protects and promotes the rights and responsibilities of people]

C12 In delivering more person-centred services, more attention needs to be given to affording choices to users and matching users with care workers. [HSC446 Manage a dispersed workforce to meet the needs and preferences of individuals at home]

D1 Shared sets of behaviours, values and professional cultures are required across sectors and organisations to give workers a foundation on which to build. Joint qualifications and joint training sessions would contribute to this.

D4 A better understanding of the roles of all those working in service users' homes would help clarify where responsibilities begin and end and where duplication may take place. An audit might be appropriate and especially pertinent for rural areas.

E1 Care workers should be supplied with a professional guidance/advice hand book with scenarios to aid training and facilitate the sharing of good practice with regard to working alongside carers. [HSC227 Contribute to working with carers in the caring role]

E2 Care plans need to truly show the perspective of carers and consideration needs to be made of how the needs and views of carers are embraced in the services delivered. [HSC428 Assess, implement and review programmes of support for carers and families]

E4 The training of care at home workers requires to cover issues relating to safeguarding and how they may be alert to possible abuse. [HSC240 Contribute to the identification of the risk of danger to individuals and others; HSC24 Ensure your own actions support the care, protection and well-being of individuals]

Linking to Recommendation 2

A18 There should be a review of the assessments that are undertaken to see what more of a role care workers and frontline managers might play. An enhanced role, subject to competency, would be one way to professionally develop workers (through formal accreditation, maybe as part of the QCF). Importantly, it could relieve some of the pressures in the system. We should investigate, furthermore, using a '*trusted assessor*' framework where possible. [HSC328 Contribute to care planning and review]

B3 Contracts monitoring should include attention to the way that providers acknowledge care workers' opinions and their views of service user circumstances, care plans and changing needs. [HSC415 Produce, evaluate and amend service delivery plans to meet individual needs and preferences]

D8 Key workers should be considered as care co-ordinators given that they have an existing relationship with the service user and the family. [HSC233 Relate to, and interact with individuals]

Linking to Recommendation 3

B2 The commissioning debate needs to be linked to the partnership debate. Local partnerships should appoint innovative and imaginative lead commissioners. Lessons can be learnt from the Local Service Boards pilots. [CPC 501 Develop strategic partnerships and alliances for commissioning]

B4 From the point of view of service providers there is duplication in the data collection required to satisfy regulators (CSSIW) and commissioners (local authorities). A system should be developed where information is shared so that providers can supply the data once.

B6 Continuing care funding is not new but is a growing area. Having two sources of funding and control is a potential problem. One solution might be the shared responsibility and funding of care packages like in Monmouthshire. [CPC 412 Work with partners to jointly commission services]

C5 Reablement assessment teams should be used more extensively across the whole of Wales to review care packages. But capacity is needed for the support of those with long term care needs after reablement. [HSC415 Produce, evaluate and amend service delivery plans to meet individual needs and preferences]

D2 The workforce philosophy needs to be challenged so that there truly is one workforce operating, where appropriate, across health and social care. Effective partnerships at commissioning, strategic and management levels are essential. [CPC 501 Develop strategic partnerships and alliances for commissioning; 412 Work with partners to jointly commission services; D17 Build and sustain collaborative relationships]

D6 There is a real need to be able to speak on common terms and so a standardised language on what working across boundaries actually means needs to be adopted in job descriptions and person specifications.

D7 Co-ordination of care is a problem. There needs to be much greater precision and clarity in the language used to describe working across boundaries. [Commissioning, Procurement and Contracting NOS; HSC415 Produce, evaluate and amend service delivery plans to meet individual needs and preferences]

D10 All sectors should use the same documentation. There already is a framework that allows for the sharing information – the Wales Accord for the Sharing of Personal Information (WASPI). [HSC433 Develop joint working agreements and practices and review their effectiveness; HSC41 Use and develop methods and systems to communicate and report; HSC21 Communicate with, and complete records for individuals]

D11 Shared care packages are a good idea but throw up challenges. User information recording formats should be streamlined and only one written record should be used in the home (for both health and social care workers). [HSC433 Develop joint working agreements and practices and review their effectiveness]

D12 There needs to be a read-across between the health and social care standards and regulatory frameworks. Consideration should be given as to whether a new set of regulations for the new cross boundary workforce needs to be established. England is currently in the process of combining the two into a hybrid system. [CPC 510 Develop a joint strategic needs assessment and delivery strategy; CPC 504 Negotiate the agreement and implementation of sustainable commissioning strategies for positive outcomes]

D13 Co-located health and social care teams would allow a number of issues to be resolved: status, training, culture and values, isolation. [HSC433 Develop joint working agreements and practices and review their effectiveness]

D14 Single budgets invoke single management plans, and the medical and social models of care can be reconciled. [CPC 510 Develop a joint strategic needs assessment and delivery strategy; CPC 504 Negotiate the agreement and implementation of sustainable commissioning strategies for positive outcomes]

E7 Communication between agencies, including the voluntary sector, has especial value in building local capacity within communities. The '*village warden*' in Herefordshire and '*Village Agents*' initiatives in Gloucestershire are worth exploring. [HSC433 Develop joint working agreements and practices and review their effectiveness]

Linking to Recommendation 4

A5 Commissioning and assessment practice needs to change to contract more appropriate amounts of time (whether more or less than is currently in place) to do what needs to be done. [Commissioning, Procurement and Contracting NOS]

B5 More flexibility needs to be given to the reallocation of care and support across existing contracts in response to the changing needs of users [Commissioning, Procurement and Contracting NOS]

C18 The CSSIW website should be developed to give guidance to providers that helps them understand what the regulator would consider to be acceptable flexibility and within the bounds of safe practice.

C20 When care workers are being selected some basic requirements around food preparation should be considered. The fact that users may have good knowledge of such matters may be an opportunity to help learning by care workers. It should not be assumed that the taking of food / meals necessarily is within the home. [HSC213 Provide healthier food and drink for individuals]

F1 There are a number of barriers to change that need to be overcome if effective progress is to be made towards outcome-focused working:

There is a lack of trust among some professionals in '*new*' ways of working.

There is a need to distinguish between outcomes for individual service users (which are relatively easy to establish) and for the whole care at home service (which are not). Data for both needs to be collected.

Many people will be unwilling to do the work for the (low) wages offered given the changed expectations for care at home workers.

Regular reassessments and feedback are necessary parts of new ways of working. New procedures will need to be put in place.

F2 The outcome-focused approach should be relationship-centred, acknowledging family, community, and others things that impact on quality of life. The '*Senses Framework*' (Nolan et al, 2006) offers a useful framework for considering outcomes. [HSC414 Assess individual needs and preferences; HSC417 Assess the needs of carers and families; HSC415 Produce, evaluate and amend service delivery plans to meet individual needs and preferences; HSC428 Assess, implement and review programmes of support for carers and families]

F4 Quantitative data can be constraining and is not suited to proving whether outcomes have been achieved. There is a need to be more imaginative regarding data collection (and to include user views and opinions) and build this into management reviews. [HSC442 Monitor and evaluate the quality, outcomes and cost-effectiveness of health, social and other care services; CPC 305 Work with providers to monitor and review performance against outcomes]

Linking to Recommendation 5

C3 Local authorities could play more of a role in vetting and barring potential personal assistants and providing employment support [LMCA3 Actively engage in the safe selection and recruitment of workers and their retention in care services]

C7 In order to challenge the dominant culture of risk aversion, it would be appropriate for agencies to introduce, where appropriate, audit and training procedures that support staff to follow their professional judgement to meet the clients wishes wherever possible. [LMCC2 Develop risk management plans to support individual's independence and daily living within their home]

C8 More emphasis needs to be given to engaging with service users (and their families) with different language and cultural backgrounds in order to understand their needs and assist planning. [CPC 408 Research the needs of the local population for the provision of services; CPC 407 Ensure the engagement of individuals, families and communities in all commissioning activities]

C13 Direct payments and micro-commissioning could be used more frequently and more explicitly to ensure that service users' perspectives are at the centre of the care package they receive. [HSC443 Procure services for individuals; CPC 418 Plan the development of self-directed support; CPC 511 Implement self-directed support in your organisation]

C14 Service users should be trained to interview care workers and managers, providing this important perspective in the recruitment process.

E6 The Local Area Co-ordination (LAC) and Self Directed Support (SDS) models should be explored. [CPC 511 Implement self-directed support in your organisation; CPC 418 Plan the development of self-directed support; CPC 314 Support the development of self-directed support]

APPENDIX 12 | IMPLICATIONS OF THE RECOMMENDATIONS FOR THE COMPETENCE OF THE WORKFORCE AND THE NATIONAL OCCUPATIONAL STANDARDS

The recommendations in this report have been carefully analysed to identify their implications for the competence of the care at home workforce at all levels. Where the evidence suggests some sections of the workforce need to reinforce current competence requirements, the relevant National Occupational Standards (NOS) are shown in bold. Where members of the workforce may need to extend their competence into new functional areas, indicative titles for NOS are shown in italics.

1. RECOGNISE THE VALUE OF THE CARE AT HOME WORKFORCE

Central to this recommendation is the registration of all those involved in providing care and support at home.

It is envisaged that individuals will register in a particular '*class*' reflecting the broad role they carry out (e.g. support worker, care coordinator, service manager) and specifying their '*role profiles*' (NOS, qualifications and QCF units applying to this class). Some of the NOS or QCF units would be core (i.e. applicable to all workers in the particular class), while others would be optional, depending on the specific role and context.

Publishing role profiles for the different classes on the register will allow workers to gain a good understanding of the requirements for different roles and therefore plan their career progression.

2. ENHANCE THE ROLE OF THE WORKFORCE IN ASSESSING NEEDS, PLANNING, COORDINATION, REVIEWS AND WORKING ALONGSIDE OTHERS

Commissioners and managers set the parameters in which the front-line workers may operate and must take decisions about their flexibility and the extent they are involved in assessing, planning, coordinating and reviewing services.

High levels of competence in the following two NOS are important to securing the baseline here:

HSC25 Carry out and provide feedback on specific plan of care activities

HSC244 Manage and organise time and activities to support individuals in the community

However, front-line workers of the future will probably need to extend their competence beyond current requirements in the following function:

Contribute to assessing, planning and monitoring and reviewing support for individuals in their homes

Existing NOS may need to be reviewed or new NOS developed which specify the new performance, knowledge and skills requirements for this function.

3. ADDRESS THE WORKFORCE IMPLICATIONS OF DEVELOPING INTEGRATED SERVICES

This recommendation relies on policy decisions to be taken at the highest level and to be cascaded through joint commissioning and partnership working arrangements.

Commissioners will need to be competent in NOS such as:

CPC 412 Work with partners to jointly commission services.

CPC 501 Develop strategic partnerships and alliances for commissioning

CPC 509 Enable your organisation to align or pool budgets with a partner

CPC 510 Develop a joint strategic needs assessment and delivery strategy

The latter NOS is particular relevant to addressing the deficit of complete and comparable data about current and future supply of and demand for domiciliary care services.

Service managers will need to focus on ensuring smooth partnership working arrangements as required by competences such as:

D17 Build and sustain collaborative relationships

HSC399 Develop and sustain effective working relationships with staff in other agencies

Care at Home: challenges, possibilities and implications for the workforce in Wales

HSC433 Develop joint working agreements and practices and review their effectiveness

LMCD2 Manage workers within care services who are based in external multi-disciplinary teams

Front-line workers will need strong competences in:

HSC241 Contribute to the effectiveness of teams

HSC228 Contribute to effective group care

4. SUPPORT THE WORKFORCE IN DELIVERING OUTCOME- AND PERSON-FOCUSED SERVICES

The NOS for Commissioning, Procurement and Contracting contain a specific, high-level standard relating to person-focused commissioning:

CPC 502 Maintain governance of a person-centred commissioning culture that promotes inclusion, cohesion and regeneration

They also contain a NOS promoting innovation throughout the system:

CPC 427 Plan, implement and manage the sharing of knowledge and good practice to inform innovation and improve delivery

The Health and Social Care NOS may, however, need to be reviewed to ensure that they reflect current best practice in outcomes-focused working and do not simply support individuals in their daily living activities. It may be that a new NOS is required for front-line workers along the lines of:

Support individuals to work towards targets for improving their health and wellbeing.

Working in partnership with service users and carers is emphasised, which require strong competences in:

HSC233 Relate to, and interact with individuals

HSC227 Contribute to working with carers in the caring role.

5. EXPLORE THE WORKFORCE CONSEQUENCES OF NEW SERVICE OPTIONS AROUND SELF-DIRECTED SUPPORT

The NOS for Commissioning, Procurement and Contracting contain specific standards relating to self-directed care, for example:

CPC 309 Support individuals, families and communities to commission their own services

CPC 314 Support the development of self-directed support

CPC 418 Plan the development of self-directed support

CPC 511 Implement self-directed support in your organisation

Guidance and training is, however, required to help commissioners, managers and assessors develop their competence in these areas.

Where service users and carers are commissioning their own services, they need to develop new competences in:

selecting appropriate forms of support (which may include technology as well as people)

carrying out the functions of employers

planning and acting cooperatively with other service users in the community.

NOS are required to define the competences service users and carers need to manage their own care/support; they then need guidance, advice and training in order to develop these competences.

A new NOS (and relevant training) will be required for personal assistants, who are working as employees of service users, covering the function of:

Manage your relationship as an employee of the service user.

APPENDIX 13 | REFERENCES

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